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CLINICAL LECTURES.

CHRONIC EMPHYSEMA. — EMPHY- SEMA WITH ACUTE BRONCHITIS.¹

BY JAMES TYSON, M. D.,
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Chronic Emphysema.

Gentlemen: This patient is sixty-six years old, and presents a negative family history. His employment has, however, some bearing on his disease. He is a machinist, and used to work a great part of his time exposed to the irritation of minute particles of dust pervading the air he breathes. He has lived, too, in a raw and cold climate, but he has always had good food and has been well clothed. He has had gonorrhœa and syphilis, and also malarial and typhoid fever.

His present illness dates twenty years back. For a long time he had a cough which was worse in winter, and this is still the case; he loses wind upon slight exertion, and is subject to attacks of dyspnoea which nearly always occur at night. It is plain that this history suggests physical examination of the patient's chest. Inspection shows a change in the shape of his thorax. You will mark that it goes down abruptly on each side, and has not the curves that we naturally find in health. It is cylindrical in shape; and this term expresses the condition better than the customary word barrel-shaped which, however, is the expression generally used to describe such a chest. You will also mark a deep depression over the sternum, and the same state of affairs over both clavicles. His rate of breathing is from twenty-four to thirty as contrasted with the normal, eighteen to twenty, respirations per minute.

By percussion we find in health that the liver dulness generally begins in the mam-

¹ Delivered at the Philadelphia Hospital.

mary line at the sixth interspace. Here, as we percuss downwards, we find that in nearly the whole area in which we ought to meet with hepatic dulness there is a resonance. This resonance extends to the eighth and even to the ninth rib before absolute dulness is arrived at. Below this the sound is dulled for the distance of a couple of fingers' breadth, and then we come to the tympany of the abdominal region. We see then that the liver is displaced downwards. Now on the left side we find this extreme resonance extending, not merely to the fourth, but to the seventh rib. The apex beat of the heart is in its normal position, but very weak and difficult to locate. On both sides of the chest the interspaces are abnormally deep. The reason for this is that, as the chest wall expands, the lungs do not follow them, so that there is in the pleural cavity a vacuum which causes these intercostal spaces to recede. The result then of our examination by percussion is that we find over both lungs a hyper-resonance which, moreover, obscures or takes the place of the dulness in the regions of the heart and liver. On the left side the dulness of the spleen is entirely concealed by the hyper-resonant lung. Behind, the chest is shaped like a cylinder and not so much like a double truncated cone, as in health. Over the regions of both scapulae the resonance is, as usual, somewhat lessened. Below them we again find this hyper-resonance extending quite down to the bottom of the chest.

On auscultation I hear a prolonged vesicular murmur, not louder but rather lower than normal. The inspiration is shortened and less loud than in health, but the expiration is prolonged, and this is more noticeable anteriorly than posteriorly. Expiration on the right side is very markedly prolonged; and on the left side, although this condition is not so striking, it is still sufficient to be noticed at once. The heart sounds are normal, but distant and difficult to hear.

The history of the case, extending over such a long period; the fact that he did not begin to lose flesh to any great degree until the last six or seven years, together with our finding everywhere hyper-resonance instead of dulness—all point to this being a case not of consumption, as one might think from hastily looking at the man's appearance, but of chronic emphysema. Now, in this disease, we have a permanent dilatation

of the air vesicles, associated with the loss of their elasticity. This condition is often compared to that of an India rubber balloon that has been overstretched until it has lost the power of contracting to its former size. Moreover, the partitions between the different air vesicles become destroyed, so that three or four of them unite together, especially at the edges of the lungs and then the organ or, at least, the part of it most affected, resembles somewhat the frog's lung.

The emphysema may be either partial or general. If it extended over the whole of both lungs, of course, the patient could not live. But I have seen *post-mortem* lungs so thoroughly emphysematous that it was surprising that their owners lived as long as they did. When these vesicles become destroyed and several merge into one, the lung becomes hyper-resonant ; and as the minute ramifications of the blood-vessels about these destroyed vesicles become, in course of time, themselves destroyed, the effort of the heart to drive the blood through the diminished vascular space becomes greater and greater until hypertrophy of the right ventricle results.

Emphysema is not a primary disease, but is a secondary result of chronic bronchitis, as is well shown in this case. It is brought about by either inspiratory or expiratory strain. When a person coughs hard he inspires deeply and much air is introduced into the lungs, and the vesicles are dilated by its entrance. Especially when it is turned aside from its usual path by obstructed areas; but expiration has probably more to do with causing emphysema than inspiration; when mucus plugs up certain of the air tubes, and the vesicles to which they lead cannot empty themselves, the latter are compressed by the chest walls and yield in the directions of least resistance and become over-distended, and lose their power to contract. These situations are the apices and edges of the lungs; and these become emphysematous sooner than the central parts. The results of this disease are, on the whole, well explained by physical laws.

As to treatment, it is impossible to restore the lost partition between the minute air vesicles or to reduce them to their natural size. Our great aim should be to get the afflicted person to accommodate his manner of living to his diminished air space. The emphysema is not only dependent upon the accompanying bronchitis, but is greatly aggravated by it, and as this latter affection be-

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comes better or worse so is the former trouble lessened or increased. Therefore, we must treat the accompanying bronchitis. When the disease is chronic and expectoration profuse, the stimulant expectorants are indicated, of which there are none better than the carbonate of ammonium. Seneca is included in the same category. These should be exhibited in doses of from five to ten drops of the latter and five to ten grains of the former. Counter irritation in the form either of tincture of iodine or a weak mustard plaster—say one part of mustard to four parts of flour or Indian meal—so that it may remain on for a good while, is also of value. As an alternative during the chronic condition, we may resort to the use of the iodide of potassium, while the tincture of belladonna is useful in relaxing spasm; for during the acute exacerbations or the attacks of asthma the symptom of dyspnea is so serious and painful, that we have to resort at once to some special treatment to relieve it. Now the cause of this shortness of breath is an imperfect aeration of the blood, because the air in the lungs is not kept sufficiently renewed. What is wanted is a more satisfactory interchange between the external atmosphere and the air in the lungs and whatever will contribute to this end is beneficial. Therefore it is well for the patient to accustom himself to the habit of alternately compressing and relaxing his chest walls with his hands, or, what is better, have this alternate compression and relaxation practiced upon himself by another person, so that his lungs may become thereby more perfectly emptied of their worn-out air. This same object is accomplished by breathing into rarefied air or by breathing condensed air. In the former case the air-chamber into which the patient breathes, being under less pressure than the air in his lungs, there is a comparative vacuum outside, so that by this means the air in the remote parts of the lung is drawn out and then, of course, its place in the lung filled out by fresh air from the outside. The same effect is gained, though in a different way, by one's breathing into condensed air. Here, the air being under greater pressure than that in the patient's lung, forces itself into the different parts of that viscous, into the remote air cells and thus brings about the interchange between the external and external air. This plan is not so good as the breathing into rarefied air. For these acute attacks of asthma, which so frequently accompany the emphysema, the

best medicinal treatment is either by nitrate of amyl, chloroform, belladonna or the iodide of potassium. Pearls of the nitrite of amyl may be carried by the patient about with him and one of them may be broken and its contents inhaled when needed. If the chloroform is inhaled, it would be necessary for it to be administered by another person. The tincture of belladonna may be given in small doses, often repeated. Iodide of potassium would have to be administered for a long time to do any good. A very useful remedy is strychnine as an expiratory stimulant. It should be given in full doses, certainly as much as $\frac{1}{10}$ grain and even $\frac{1}{8}$, reached by gradual increase from smaller doses.

Emphysema with Acute Bronchitis.

This next patient is much younger than the one who preceded him. His occupation has been that of a laborer. Here, too, the family history is negative. His health was good in childhood. He, too, worked in dust; has been pretty freely addicted to the use of alcohol and has had specific disease. He had an attack of pneumonia in 1884 and this probably has some connection with his present complaint. He has had a cough, worse at times, and attacks of dyspnea for the last four years. He also had bronchitis, which was worse in the fall and winter seasons and, moreover, attacks of asthma which nearly always occurred at night; so that he has, on the whole, a good many symptoms similar to the other case.

Upon examining him by inspection we find that he, too, presents the condition characteristic of constant expiratory strain. Here, too, we see the cylindrical or barrel-shaped chest, which is straight up and down, with deep depressions between the ribs and about the clavicle where the muscles are attached. He presents the superior thoracic type of breathing—that of woman. Percussion on the right side shows resonance down below the seventh rib, because the liver is displaced downwards by the lung. The heart's dulness is obscured by the overlying lung and that of the spleen is hardly perceptible. By auscultation we find that the inspiratory murmur here is louder than in the former case. The characteristic peculiarity of emphysema, that the duration of expiration is increased while that of inspiration is decreased, is here very marked. We hear also "cooing" râles, which are

symptoms of bronchitis. This is what we might expect, as the man did not come into the hospital until yesterday. In addition to the cylindrical-shaped chest, upon examining this man behind, we find that he has the drawing together of the scapulae and that consequent deepening of the vertebral gutter. These phenomena are also common in emphysema, from the overwork of the muscles in their efforts to make the chest walls accomplish or supplement the imperfectly performed functions of the lungs. Moreover, this is a local disease and in this case it is more marked on the left than on the right side, that is, the resonance and other signs of emphysema on the left are more marked than on the other side.

Under the head of treatment may be mentioned in this case the comfort and rest of a hospital. These patients who are poor nearly always improve as soon as they come here, independent of the medicines they receive; because they get good food, rest and protection from the weather. As this man was only admitted yesterday, the symptoms of his disease are rather those of acute bronchitis. We do not hear the moist bubbling, as in the previous case, but sonorous and sybillant râles. Therefore, we do not need the stimulant, but relaxing expectorants, such as tartar emetic or ipecac. He might now take a prescription like one of the following :

R Syrup of Ipecac	f $\frac{3}{4}$ ss.
Sweet Spirits of Nitre	f $\frac{3}{4}$ vj.
Simple Syrup, or Syrup of Wild Cherry	f $\frac{3}{4}$ ss.
Neutral Mixture, enough to make	f $\frac{3}{4}$ vi.

Sig. Take one tablespoonful every three hours.

Later we may add to this prescription two drachms of the muriate of ammonium or still later, carbonate of ammonium, omitting the ipecac altogether. Locally he should have upon his chest a large, warm mustard poultice, composed of one part mustard and four parts corn meal, which may be left on for some time.

—The special board of engineers appointed by the Secretary of War to examine and report upon the most available point on the Gulf coast west of the Mississippi for a deep-water harbor have selected Galveston. Their report is now before Congress. The expense of improving Galveston harbor so as to fulfil the requirements is estimated at \$6,200,000.

EMPHYSEMA.—EMPHYSEMA WITH BRIGHT'S DISEASE.—EMPHYSEMA COMPLICATED WITH PHTHISIS.

BY J. M. ANDERS, M. D.,
PHILADELPHIA.

Emphysema.

Gentlemen: The history of the first man whom I show you to-day is as follows: He is fifty-nine years old; his family history reveals that his father died of phthisis at an old age, his mother living to an old age also and having had emphysema and asthma. When a boy he had typhoid fever, and at twenty he had what was thought to be brain fever. After that he was well until twenty years ago when he had an attack of articular rheumatism. Four years ago he began to suffer from asthmatic attacks, terminating with profuse expectoration. From these symptoms one would expect the presence of emphysema and it is with this idea foremost in my mind that I begin to examine his chest.

Inspection shows that the thoracic portion of the spinal column is more curved than normal. There is bulging behind and in front—a prominence giving to his chest the characteristic barrel-shape. His inspiration is quick and short; his expiration, prolonged and labored. When he breathes, the whole chest is moved slightly upward and downward as one solid casing. The normal elasticity of the lungs is not sufficient, hence they do not empty themselves at each breath. Thus there is a great amount of the residual air left behind them at each respiration. The intercostal spaces protrude behind. The heart is overlapped by the lungs. The apex beat is much displaced towards the right side and also in a downward direction. For these reasons the area of cardiac dulness is very small.

Percussion reveals hyper-resonance over his entire chest. The percussion note in emphysema is never purely tympanitic, but partly of a vesicular quality. The lung has pushed down the diaphragm and the breathing is, to a great extent, abdominal. Some physicians go so far as to divide all cases into those characterized by abdominal

¹ Delivered at the Philadelphia Hospital.

respiration and those in which the respiratory movements are more marked above.

Auscultation shows a prolonged wheezing expiration, and when you have associated the three signs : weakened vesicular murmur, prolonged expiration, and hyper-resonance on percussion, you may be certain of the existence of emphysema. Pneumothorax gives rise to a hyper-resonance at first ; but here auscultation reveals exaggerated respiratory sounds. In pleurisy there is flatness on percussion when effusion takes place. In phthisis we get dulness on percussion, generally in one of the upper lobes, together with harsh vesicular murmur, and more or less bronchial breathing. In capillary bronchitis you have greatly hurried breathing, a rise of temperature, a bad cough, and the expectoration of considerable sputum. Pleurisy generally affects both lungs and in this respect resembles emphysema, which also usually affects both organs in the course of time.

During the progress of emphysema the patient is often comparatively comfortable in summer, but in winter the cough and asthma set in again. The associated bronchitis often bears a causal relation to this disease, especially when the emphysema is local. When the bronchitis comes late in the disease it is due to a passive congestion. In this man's case the bronchitis preceded, and was the cause of the emphysema. Therefore, it is worse in winter.

If emphysema is due to some sudden great effort, or is brought on in children by the whooping-cough, it is often curable. Jenner thinks that this disease is due to a fibroid degeneration of lung tissue, while Williams attributes its causation to fatty degeneration. The indications for treatment are to arrest the degeneration by iron and aperient and to restore the power of the over-distended lung. This latter object is best accomplished by breathing condensed air, at the same time expiring into rarefied air. Then you should always treat the associated bronchitis. The asthma, too, may require special treatment. Each hospital has its formula for cigarettes, which give temporary relief.

Again, the tincture of lobelia is given in twenty-drop doses every half hour until the symptoms are relieved. In order to break up the tendency to recurring attacks of asthma, the iodide of potassium in ten-grain doses, three times a day, is recommended.

Emphysema with Bright's Disease.

This man is seventy years old, and he comes from a long-lived family. His father died, at the age of eighty-four, of articular rheumatism and his mother of old age. He had eleven brothers and two sisters and his own family number ten children, all of whom, except one, are still living. He had rheumatism last year, and in May, 1889, he was seized with dyspnoea and fever, together with a fearful headache. He went to the Episcopal Hospital, where he was treated for bronchitis and asthma. He left there at the end of three weeks slightly improved. He has had one attack of asthma while here and for this he received a hypodermic injection of morphine.

Examination by inspection shows that the chest is enlarged, but not barrel-shaped. The apex beat of the heart is seen in the epigastrium. Percussion, too, confirms the testimony of inspection that the heart is displaced downward, and that the area of its dulness is decreased. There is increased resonance of the lungs. Auscultation reveals a weakened vesicular murmur and the expiration is prolonged. The main physical signs are : weak vesicular murmur, prolonged expiration and semi-tympanitic resonance ; and they point to emphysema. When he was admitted he was treated for chronic bronchitis. The emphysematous condition persisted and the attacks of asthma at night grew worse. About three weeks ago his urine showed some albumin and some epithelial and granular casts. Some authorities say that all cases of emphysema, that terminate fatally, exhibit albumin and casts in the urine. While I am prepared to admit that it does occur at times, I think it is going too far to claim that it occurs in all, or anything like all, fatal cases. When Bright's disease does occur it is in the majority of instances the large, white kidney, whilst it sometimes takes the form of chronic congestion. Many of these cases of kidney disease seem to develop suddenly. In nephritic complications you will have the worst forms of nocturnal asthma. As this man's urine indicates Bright's disease and he is already anemic, he will be given one tablespoonful of Basham's mixture three times a day.

Emphysema complicated with Phthisis.

This old man's occupation is that of a laborer. His family history is good. At

fifteen he had pleurisy; twelve years ago he had typhoid-pneumonia, and later, cough, profuse expectoration and night-sweats. He recovered from this, but later began to cough again. He was admitted here a good while ago and showed then serious lesion at the apex of the left lung. Here the emphysema is only partial or compensatory. There are some who say that you cannot have emphysema and phthisis in the same subject, that in emphysema you have an anemic condition of the lungs, while the great requisite in phthisis is hyperemia. But in this case we had, first, a tuberculous process, and later a compensatory emphysema. The antero-posterior diameter of the right chest is enlarged, and we have a distinct impulse of the heart's beat beyond the nipple line. In emphysema the right side of the heart is frequently dilated from general capillary stenosis of the lungs.

On ausculting the right side of the chest I get a weak vesicular murmur and prolonged expiration; and on percussing, hyper-resonance. On the left side I hear subcrepitant râles everywhere, distant bronchial breathing and the percussion resonance is diminished. Therefore, the whole of the right lung has undergone hypertrophic emphysema while the left lung has been becoming tuberculous. In cases like this the prognosis is grave and the treatment should be, to a great extent, directed to the general condition.

COMMUNICATIONS.

TROPHO-NEUROSIS AS A FACTOR IN THE PHENOMENA OF SYPHILIS.¹

BY G. FRANK LYDSTON, M. D.,
CHICAGO, ILL.

[CONCLUDED.]

Even in congenital syphilis we can see evidences of tropho-neurotic disturbance. The peculiar affinity of the syphilitic process for the epiphysio-diaphysial junction of the long bones is strikingly suggestive. It is here that the processes of growth and nutrition are most active, and tissue building most rapid. It is, consequently, at this point that disturbance of the trophic function of the sympathetic which presides over the physiological processes of nutrition and

growth would be most likely to be manifested by pathological changes. A perversion of the function of the sympathetic would result in imperfect differentiation of the cells of the part; and, as the rapidity of proliferation of cells is in inverse proportion to their degree of differentiation, a heaping up of the young material is to be expected. Associated with this imperfect differentiation of cells, we have a tendency to degeneration; for it may be formulated that the tendency to degeneration is also in inverse ratio to the degree of differentiation. This imperfect differentiation, with a consequent tendency to degeneration of young germinal material, is the characteristic feature of all the lesions of syphilis, no matter at what stage of the disease they may develop.

The physiological effects of the remedies upon which we depend for the cure of syphilis are evidences of the neurotic character of syphilitic phenomena. It is shown that mercury and iodide of potassium, although very efficacious in syphilis, are in no sense directly curative, their beneficial effects being dependent upon their power of inducing fatty degeneration and elimination of the products of the syphilitic process rather than upon any special controlling or antidotal effect upon the poison *per se*, whether this poison be a virus, germ or cell. In reviewing the opinions of our best syphilographers regarding the treatment and prognosis of syphilis, one is impressed with the idea that syphilis is a disease which runs a natural course in spite of treatment, the physician being incapable of doing more with his remedies than to remove the effects of the disease as fast as they appear, thus preventing as far as possible permanent damage to the affected tissues. As far as aborting the natural course of the disease is concerned, he is absolutely helpless; and apparently his success in the treatment of the disease is inversely to the vigor of his attempts to antidote or stamp it out.

If the neurotic theory of the essential condition in syphilis be correct, in our efforts to discover a specific remedy for syphilis we have been necessarily led away from those lines of research which would lead to a correction of the principal element in the production of the syphilitic phenomena. The severity of the results of syphilis would appear to depend (1) upon the individual susceptibility of the nervous system of the patient; (2) upon his constitutional

¹ Read at the meeting of the Southern Surgical and Gynecological Association.

condition, and, incidentally, on the resisting power of his tissues; (3) upon the action of remedies, this being by no means the most important consideration.

The involvement of the fauces and pharynx characteristic of secondary syphilis, has been explained upon the ground of lymphatic engorgement, the primary cause of which is the abundance and superficial character of the lymphatic capillaries of the affected parts. It is a noteworthy fact, however, that there is but little swelling, pain and tenderness accompanying the syphilitic sore throat, provided ulcers be absent. There is also little or no tendency to ulceration in the majority of cases in the early part of the disease. There is comparatively little heaping up of syphilitic material. These characters would lead one to suppose that there is something behind the localized proliferation of cells—if such exist; something, too, which will explain the appearance of morbid phenomena at this particular point, aside from mere anatomical peculiarities. For obvious reasons it has not been clearly shown whether the same efflorescence and engorgement does not occur in the other portions of the alimentary canal in the early period of syphilis. Admitting that there is a diffuse accumulation of cells in the pharyngofacial tissues, there should be something more than local anatomical peculiarities to explain it. Is it not a result of vaso-motor changes similar to those which prevail in the roseola, and which are due to the impression of the syphilitic poison upon the central nervous system? The same condition, in all probability, prevails in other portions of the alimentary tract, which, as is well known, are intimately associated with the sympathetic nervous system. It is only at this point, however, that the parts affected are so superficial as to be open to observation. At this point, moreover, causes of irritation are more prevalent than in other portions of the alimentary tract. The food which is swallowed, rapid changes of temperature incidental to the function of respiration or to the ingestion of fluids at various temperatures, the use of the voice, the contact of irritating secretions from the nose, and the inhalation of irritating substances from the atmosphere, might quite rationally be expected to contribute to the tendency to localization of the syphilitic process in the throat. In the presence of such local causes of irritation, vaso-motor disturbance incidental to the impression of the syphilitic

poison upon the central nervous system might be determined at this point, while absent in every other situation.

As we have seen, the vaso-motor impression which underlies the development of the roseola is substituted later on for a more or less pronounced trophic disturbance, as manifested by the heaping up of neoplastic material, the development of pus, the occurrence of ulcerations, etc. *Pari passu* with the supervention of this trophic disturbance in the case of the skin we have a similar state of affairs in the pharynx and mucous membrane of the mouth, as manifested by the development of mucous patches, ulcers and macular eruptions, the latter being particularly marked upon the roof of the mouth.

On careful observation of successive crops of lesions in syphilis, it will be found that the tendency to destruction of tissue and to the involvement of various important functions of the body grows more pronounced as the case progresses. We see, therefore, in watching a case from its inception, the gradual supervention of a trophic upon a vaso-motor disturbance, and as the case progresses this trophic aberration becomes more and more pronounced, until finally in the period of the so-called sequelæ we have marked destruction of tissue in various situations—a destruction so marked as to have led to the impression at one time that the syphilitic poison produced in such instances corrosion of the tissues. In the absence of a corrosive power of the syphilitic poison—and as we know its infectious properties decrease as the case progresses—the only logical explanation of the serious effects of late syphilis is the theory of thropho-neuritic disturbance.

Let us glance at the series of morbid phenomena in a typical case, and the truth of the foregoing assertion is at once apparent.

First, we have a macular eruption or perhaps an efflorescence of the skin, which is not at all raised above the surface. This—the roseola—does not produce any destruction of tissue. Later on we have the development of papules; a little later in the natural order of succession, pustules, perhaps followed by ulceration. Still later we have marked ulceration of an ecthymatous or perhaps rupial character. Interspersed with these various later lesions or occurring alone, we may have a development of scaly lesions,—sometimes tubercular syphilides. Coincidentally with the papules we have the ap-

pearance of sore throat, followed later on by mucous patches and perhaps ulceration. As the case progresses, the bones may be affected; iritis may occur; well along in the period of sequelae, necrosis of the bones may develop. It will be found that the tendency to suppurative processes and to destruction of tissue increases as the intensity of the infection diminishes. The later lesions are found to be frequently associated with disturbance of a known nervous character, cerebral syphilis in its various forms being quite apt to occur.

The exceptions to the gradual increment of severity of syphilitic lesions are so unusual that they are now designated as precocious. Malignant or precocious cases of syphilis are explicable in my opinion only upon the theory of idiosyncrasy.

It is in the late secondary and sequelar lesions of the disease that the apparent tropho-neurotic character of the manifestations is most pronounced. I had long been impressed with the peculiar course of some of the lesions of bone in late syphilis, particularly those affecting the head and face. It had seemed to me that the destructive effects exerted by the morbid process upon the bony tissue was greatly disproportionate to the objective and subjective phenomena which preceded the actual destruction. For example, I think that, upon reflection, it will be found that the objective morbid phenomena which precede the necrosis *en masse* of various portions of the palate and of the superior maxillary and nasal bones are comparatively slight when we take into consideration the fact that the affected bone is entirely destroyed. Indeed, it often seems that the first objective phenomena perceptible in cases of necrosis of the parts mentioned is incidental, not to the destruction of the bone, but to an attempt on the part of nature to rid the tissues of offending foreign material. Thus I have observed cases in which the greater portion of the palate was entirely destroyed, yet very little manifestation of trouble was apparent until suppuration occurred with a small point of ulceration of the soft parts covering the bone and the discharge of a small quantity of pus—a quantity, by the way, so small as to be entirely disproportionate to the extent of the morbid process. On passing a probe into the small sinus thus formed, one who is not thoroughly conversant with the peculiarities of such conditions would probably be surprised to find that a large portion of the

bone is dead and perhaps loose in the tissues. It will be found upon observation of processes other than syphilitic, which produce necrosis or caries of bone, that there exists prior to the death of the bone structure, quite pronounced objective phenomena in the way of pain, swelling and deformity of the part, these symptoms indicating the existence of proliferated inflammatory material which subsequently produces destruction of the vitality of the bone by simple pressure. Those morbid phenomena in syphilis, which involve bone or periosteum in the early part of the course of the disease, are accompanied by objective phenomena relatively more prominent than those late lesions which are now under consideration; yet, at the same time, they are rarely followed by caries or necrosis. These processes, it seems, are reserved for the late secondary or sequelar period of the disease. Thus it will be seen that, although the local process is apparently more severe in the early cases, destruction of the vitality of the bone is not so likely to occur. There is a marked difference between the nodes and diffuse sub-periosteal swellings of early syphilis and the condition of the bone and periosteum which precedes necrosis *en masse*, or, for that matter, caries, in the late stages of the disease. In addition to the disproportion between the degree of destruction of bone and the objective phenomena preceding such destruction, another point worthy of comment is the fact that syphilis possesses the power of dissecting out definite portions of bone tissue, apparently by cutting off their nutritive supply—in a manner as clean as could be effected by the knife. Thus I have specimens in my possession of the intermaxillary bone, portions of the alveolar process of the maxilla, the palatal and nasal processes of the superior maxilla, the malar bones and the nasal bones, which became necrosed and loosened, and were removed from cases of late syphilis. These fragments of bone present as natural a conformation in many instances as in their healthy condition.

As far as I have been able to observe, there seems to be a special predilection in cases of late syphilis for those parts supplied by the fifth nerve, indicating that the portion of the sympathetic system which presides over these parts is especially sensitive to the syphilitic impression.

I have found in some instances the tendency to unilateral destruction of bone

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tissue particularly marked. Thus the palatal process of the superior maxilla upon one side, or the superior alveolus upon the other, may necrose and give way without the corresponding portion of bone becoming affected. Indeed, it seems that in most instances in which necrosis attacks the bones of the face, it is impossible to check the process until the line of demarkation represented by the anatomical outline of the affected bone has been reached. The peculiar manner in which one-half of a structure may be dissected away by the sequelar lesions of syphilis, is exemplified by a case of syphiloma of the tongue which recently came under my observation, in which the sloughing of the organ was limited by the raphe.¹ This case subsequently went on to malignant transformation. I removed the tongue with the galvano-cautery; the disease recurred; and the patient died of hemorrhage several months later.¹

I have had several cases recently in which that portion of the superior maxilla corresponding to the intermaxillary bone was dissected out by the syphilitic process, with resultant loss of the incisor teeth, the remainder of the jaw remaining intact. There appears to be a peculiar predilection of late syphilis for this portion of the jaw. I have several cases in which caries occurred in this situation, with a consequent loss of one or more perfectly healthy teeth. These cases have appeared to me to be so characteristic that I have come to regard loss of the incisor teeth, without any apparent cause, as almost positive evidence of syphilis.

An interesting case, illustrating the unilateral limitation of some late lesions of syphilis came under my observation recently. The patient was a gentleman who had an obscure history of syphilis, dating some years back. Several weeks before coming under my observation, ulceration began at the roots of the molar teeth upon one side and extended outward to the palate. When I first saw the case the ulceration had extended outwards upon the hard palate for about three-quarters of an inch and forward to the median line, when it abruptly stopped. The appearance of the ulceration was quite typical. There was no disease of the teeth or jaws to account for it. Healing was quite rapid under appropriate anti-syphilitic treatment.

Another interesting case of a somewhat similar character is that of a gentleman who had syphilis seven or eight years ago. For the last three or four years he has had occasional symptoms of the disease. A few months ago ulceration occurred about the roots of the upper incisor teeth, and was attended with slight caries of the intermaxillary bone. The process was checked by appropriate treatment; the teeth, which were loosened, finally becoming perfectly solid. About six or eight weeks after the ulceration was healed the patient consulted me for supra-orbital and infra-orbital neuralgia and hemicrania. This resisted all treatment, except anti-syphilitic remedies. It yielded readily to iodide of potassium in large doses. Within a few days the patient has again consulted me for paraesthesia of the right side of the face, which he noticed for the first time while being shaved. His face having been excessively tender before, he very speedily noticed a lack of sensibility under the razor. Associated with this paraesthesia, there is obscure pain, which he locates back of the eyeball. The *ensemble* of symptoms in this case points to central disturbance, and shows a manifest predilection of the sequelar lesion for the fifth cranial nerve.

The association of obstinate tubercular syphilides with nervous syphilis is well known. It seems that the danger of involvement of the central nervous system is directly proportionate to that of severe syphilides.

In considering the tropho-neurotic character of the late lesions of syphilis, I do not ignore the fact that syphilis may act directly upon the nervous system in several different ways:

1. By the direct effect of syphilitic deposit upon the nerve cells or fibres, or membranes of the brain and spinal cord.
2. By changes in the membranous envelopes of the brain and spinal cord.
3. By deposits in and about the blood-vessels which induce circulatory disturbance.
4. By a proliferation and condensation of connective tissues which remains after the syphilitic material *per se* has been removed.

There is probably a difference in the late and early forms of syphilitic lesions, in the manner in which the tropho-neurotic element is brought about. Thus it may be due, in the first place, to a direct impression of

¹ Apparent cancerous transformation of syphiloma of the tongue. Amputation by the galvano-cautery. *Medical Record*, Oct. 26, 1889.

the syphilitic poison upon the sympathetic nervous system; secondly, upon direct pressure upon the nervous structures; thirdly, upon a disturbance of function and nutrition of the nervous structures incidental to interference with blood supply.

It is probable that mercury acts upon the nervous system in very much the same manner as does syphilis. It is very difficult to differentiate late syphilitic lesions of the bones and of the mucous membranes from those directly due to the action of mercury. That mercury exerts a powerful effect upon the sympathetic nervous system is, it seems to me, shown conclusively by the phenomena of ptyalism, which cannot be accounted for solely upon the theory of the production of irritation. The well-known power of mercury over the secretions is probably due to its influence upon the sympathetic ganglia. When the injurious action of mercury is superadded to syphilis, there is a more marked tendency to tropho-neurotic phenomena than in well-treated cases of the disease. Indeed, the excessive use of mercury often seems to determine the predilection of late syphilis for the bones of the head and face. It is quite as capable of producing necrosis or destructive ulceration of these parts, as is syphilis *per se*.

Positive demonstration of the dependence upon nervous disturbance of the phenomena which I have outlined is, of course, difficult; but the inferences which I have drawn appear to me to be logical. In considering the question of trophic disturbances, in their relation to destructive syphilitic processes, it is well to remember the familiar physiological experiment of section of the sympathetic in the neck of the rabbit. The same experiment is also interesting as bearing upon the faucial congestion of early syphilis. The reddening of the ear of the rabbit, the inflammation and sloughing of the cornea incidental to section of the sympathetic are certainly suggestive. To carry the analogy of this physiological demonstration a little further, I would call attention to the serious corneal trouble which sometimes results from *herpes frontalis seu orbicularis*.

812 Opera House.

DEXTRINE MUCILAGE. — Four hundred parts of dextrine are stirred into 400 parts of water; then add 200 parts more of water, 20 parts of glucose and 10 parts of aluminum sulphate; heat the mixture to 195° F., when it will become thin and transparent.

INFLUENZA—LA GRIPPE.¹

BY WILLIAM B. DEWEES, A. M., M. D.,
SALINA, KANSAS.

Mr. President and Fellow-Members: The repeated accounts given during the pandemic prevalence of the late epidemic of influenza, in the columns of both the medical and the daily press, and a personal experience with the disease, has familiarized the profession so extensively with all the divers phases of this most unpleasant malady, that anything said on the subject may seem trite. Nevertheless, the occasion is one which cannot be allowed to pass with no formal notice and full consideration by this Society.

In presenting this subject for discussion, the time allotted allows scarce more than bringing out the more salient features, and even in this I find myself somewhat at a disadvantage. The absence of reliable statistics regarding the prevalence and progress of this wide-spread disease, makes its exact study more difficult. From the knowledge we have, influenza is not in itself a grave disease; yet its complications and the sequences are sometimes most important. This fact alone not only justifies, but demands a close examination of the clinical history of this disease—more especially as manifested during the last epidemic.

Influenza is by no means a new disease, though most of the medical men who have been graduated within the last ten years have seen nothing of it prior to the last epidemic. The earliest record known of this disease is probably found in an outbreak in the Athenian army in Sicily, 415 B. C., as recorded by Diodorus Siculus. From the ninth and tenth centuries of the Christian era, references to epidemic influenza—now called epidemic catarrhal fever or *la grippe*, etc.—begin and multiply; and from that time to the present, the literature of the subject has grown steadily. History shows that since the year 1173 to the present time, there have been sixty-two epidemics of influenza in Europe, America and elsewhere, averaging one in about every eleven years. During this period it assumed a pandemic form fifteen times. One of the most remarkable epidemics of which we have record is that which started in China in 1830, and swept rapidly over Asia, Europe and America,

¹ Read before the Golden Belt District Medical Society of Kansas, April 3, 1890.

lingering here and there, and breaking out afresh in places until 1833.

Since that time there have been a number of less wide-spread epidemics, including that which occurred in this country in 1879—in which I had my first experience with the disease. It may not be out of place to note in this connection—as most of you can recall with me—the facts of a similar disease being very extensively prevalent among horses at the same time, which was chiefly known as "pink-eye," and proved much more fatal than the disease in man. The disease has always been particularly remarkable in this, that it has been the most widely and generally-spreading epidemic known. It has seldom appeared in any one country without appearing successively in every other part of it. The last epidemic, which has just swept the world from east to west, has excited universal attention, and sufficient time has at length elapsed, even in this country, to enable us to present our recorded observations and to exchange our individual views in regard to it, founded upon actual observations and not upon mere hypothesis.

According to the journals, the last epidemic made its first appearance in Europe, where the first cases recognized were observed in St. Petersburg, October 15, 1889, its diffusion and spread being so rapid and general that by November 17 it had invaded Asia, Finland, Vienna, Paris, etc., and by December 20 it was epidemic in nearly all the capitals and large cities of Continental Europe. In this country it was first recognized in Boston, December 17, in New York City, December 20, in Chicago, December 23, etc., thus extending from the Atlantic to the Pacific, from Canada to Mexico and Central America within one month. Practically, this epidemic has extended from St. Petersburg to the Pacific Coast, over two continents from north to south, within three months—extending over a greater area and with greater rapidity than any epidemic of which we have a record.

The disease made its advent in Salina, Kansas, about December 25, 1889, gradually but surely making inroads until about ten days later, when it began attaining rapid headway, and prevailed extensively for about eight weeks. Thereafter its subsidence was marked, though less rapid than its onset, and it continues to manifest itself in isolated cases. During this period, it is safe to estimate that one-third of the population of

this city was affected by the poisonous influence of the disease, but that, owing to the mildness of the general type of the affection, probably only one-half of the number affected came under the care of the medical profession. While there have been a great many cases and much sickness, no death is directly traceable to the influenza *per se*. The total number under my care and observation during this period has been over five hundred cases, the largest number of cases I have seen sick in bed in one day being forty-one. The period of its greatest prevalence was from January 14, 1889, to February 11, 1890, during which four weeks there came under my care three hundred and ninety-six cases. In describing the disease as observed in these cases, I shall first note the general symptoms in their usual order of appearance. The disease came on like a severe cold, but with much greater and more speedy prostration of the muscular forces—general debility, surprisingly out of proportion to the intensity of the fever and the catarrhal processes. Chill, backache, headache, muscular pain, great debility of physical and mental strength and energy, fever, anorexia and insomnia were the leading or earlier symptoms in almost all well-marked cases; and these indicate the action of a systemic poison, which seemed to have a marked predilection for the nerve centres and mucous membranes, as evidenced in its progress by developing into two well-marked types: the Nervous and the Catarrhal. The symptoms as manifested under the two varieties may be classed in the following symptomatological group:

First. The Nervous Type.—The symptoms are purely nervous, being a continuation of the foregoing initiatory symptoms—minus the chill—with increased severity. Backache, headache, great debility, pains in the limbs and trunk, and frequently painful deglutition, without any disturbance of the respiratory or alimentary tract, save loss of appetite and often nausea. As a rule the severer pain occurred near to, rather than directly in the larger joints, and more generally in the muscles. In the later stages of the disease it often appeared in the lower intercostal spaces, probably by affecting the diaphragm, the patient complaining of being tight, as if bound by a band around the body, or in some single muscle, such as the deltoid, etc. I have seen cases comparatively well in three days, then suffer for six

April 2

weeks with severe pain in the left deltoid. Dizziness, sleeplessness, a tendency to fainting and sometimes hebitude, occurred mostly in women, regardless of any conditions peculiar to sex.

Second. The Catarrhal Type.—This was invariably preceded by a similar prodromic stage, and possessed throughout its course marked nervous symptoms analagous to those of the first form—backache, headache, muscular pains, great debility, anorexia, insomnia, etc. In addition to these, it was chiefly recognized by catarrh of the mucous membranes, which again manifested itself in two distinct forms—the bronchitic and the gastro-intestinal; the former being characterized by coryza, sneezing, nasal-pharyngeal and bronchial catarrh, continuing for several days after the initial fever had subsided. The latter by catarrh of the alimentary track, sometimes accompanied by profuse vomiting and diarrhoea.

Both of these varieties were accompanied by a continued fever, the temperature rising rapidly on the first day to 101° , 103° or even 105° F., in due proportion to the severity of the preceding chill, and continuing for several days—usually from one to three days, very rarely longer, where a more or less copious, acid, ill-smelling sweat marked the crisis, which was followed by a rapid decline and convalescence. It is interesting to note, that in all cases of the catarrhal type, a mild sweat preceded the oncoming of the catarrhal symptoms, which usually occurred at the end of the first day, while in those of the nervous type no such phenomenon was noticed. It was the nervous type of this disease, especially, that finished its course in a few days; for the cough and other catarrhal symptoms much more frequently continued longer; and often when they appeared to be going off, they were suddenly renewed with all their former characteristics, by any fresh exposure to cold. Hence, relapses were not uncommon among the cases of the catarrhal variety, while those of the nervous type were comparatively immune. The period of convalescence was very variable, and seemed to depend largely upon the intensity of the attack in both varieties, some persons feeling ready for work as soon as the fever had subsided, while others were unfit for any exertion, felt wearied and depressed, and suffered from continued nervous symptoms for weeks after. The rarer symptoms observed, were chiefly sharp, neuralgic pains, muscu-

lar spasms, hyperæsthesia of the skin and a scarlatinoid eruption.

The complications encountered were mainly catarrhal bronchitis, catarrhal pneumonia, dysenteric diarrhoea, otitis, otorrhœa and bronchorrhœa.

The disease was no respecter of age, sex or occupation, the oldest case under my care being eighty-six years old, and the youngest two years old. Of the 513 cases observed, my notes show the following deductions: 327 cases of the nervous type and 186 cases of the catarrhal type of the former variety. There were 287 mild cases and 40 severe cases; and of the latter 131 mild cases and 55 severe cases. 129 cases recovered in three days; 314 cases recovered in eight days; 42 cases recovered in one month; 28 cases lingered for two or three months. Relapses occurred in 68 cases: all of the catarrhal type, with but five exceptions. Of the rarer symptoms and complications, there were noticed the following:

Neuralgic pains, principally in the limbs, neck and face and frequently in the head, like hemicrania, occurred in 297 cases.

Muscular spasms, chiefly in the muscles of the limbs and neck, were noticed in 83 cases.

Hyperæsthesia of the skin of the palms of the hands and of the soles of the feet was observed in one case only.

A scarlatinoid eruption manifested itself in four cases.

Catarrhal bronchitis, complicated, 49 cases.

Catarrhal pneumonia appeared as a complication in six cases.

Dysenteric diarrhoea, profuse and alarming, occurred in two cases, both females.

Otitis, otorrhœa and bronchorrhœa each developed in but one case respectively.

The most interesting of these, to me, was the scarlatinoid eruption.¹ The four cases occurred in the same building—a four-story brick structure, with high ceilings, heated by steam and well ventilated—a boarding school, wherein about one hundred persons congregated daily, including day scholars from the city. Of the seventy persons living in the building, thirty-three were

[¹ Dr. Anton Minauf, of Seitenstettin, Austria, publishes in the *Wiener med. Presse*, March 23, 1890, a very interesting communication in regard to the eruption or rash of epidemic influenza—or the Grip—as he and Dr. Wawra observed.—EDITOR OF THE REPORTER.]

affected with well-marked influenza, including the four cases under consideration.

Case 1. Was taken January 19, 1890; temperature 103° the first day, with furred tongue, etc., which continued until the afternoon of the second day, when the peculiar eruption appeared, first on the face, then on the neck and chest and continuing until the entire body was covered. The eruption was decidedly erythematous, of irregularly outlined mottlings at first; but soon coalescence followed, when the appearance was very much like the characteristic eruption of scarlet fever. This eruption continued prominent for six hours, when a profuse sweat terminated the symptoms, and the patient, after a good night's sleep, was discharged and resumed his studies on the following day, January 21. No desquamation followed. Nothing was thought of this eruption in this case, as I ascribed it at the time to the untoward action of the quinine and chloral administered the preceding night.

Case 2. Began January 23, 1890, and on the evening of the same day, the temperature rose to $103\frac{1}{2}^{\circ}$ F. The tongue was coated, with slightly enlarged papillæ; the conjunctivæ and the fauces were very much congested; deglutition was very painful, and there was nausea and vomiting, and an eruption, similar to that in Case 1, began appearing on the face. This being noted, on my first visit, and as no medicine had yet been prescribed or taken, I became fearful of its being a case of scarlet fever. The case was duly isolated, and the nurse was instructed to allow no one to enter the room, which was kept dark, warm and well-ventilated. I prescribed a placebo, and ordered a milk diet exclusively. The next morning my notes show the temperature the same, with all the other symptoms, except that the eruption now covered the neck, chest, abdomen, and the upper part of both upper and lower limbs, presenting the same irregularly outlined mottling. By evening of the second day coalescence was established, and there was a more uniform bright scarlet hue to the eruption, which now covered the entire body. To look at the case was to pronounce it one of scarlet fever, so striking was the resemblance. I now prescribed quinine and chloral in full doses, twenty grains of each at bed-time. A good night was passed, with refreshing sleep, preceded by a profuse sweat (the effect of the quinine). On the next day morning I found the temperature

100° F., the body literally covered with sudamina, the eruption less prominent, and desquamation commencing to take place. The conjunctivæ and fauces were much less congested, and the tongue was almost clean.

The symptoms characteristic of the influenza had abated, as usual, after the action of quinine and chloral. The eruption and desquamation continued jointly in this case until February 2, by which time the eruption had faded entirely, but desquamation continued for about one week longer. The patient convalesced nicely, with full recovery to former health.

Case 3. Started January 27, 1890, the temperature rising to $104\frac{1}{2}^{\circ}$ F. the first day evening. The conjunctivæ and fauces were congested, and the tongue was coated with a thick, yellowish fur, and the papillæ were enlarged. The hearing was impaired, evidently from involvement of the Eustachian tubes. The eruption, though less marked, manifested itself on the face, neck and chest, and grew more marked day by day, having a somewhat venous congested hue and showing less mottling than in the preceding two cases. The sixth day of the disease it suddenly became more intense in scarlet hue, having now covered the entire body, and its bright color continued until February 17, when it suddenly faded after a profuse sweat. It was followed by a crop of sudamina as abundant as in Case 2. In this case desquamation commenced on the fourteenth day of the disease, and continued for four weeks. Otitis of both ears was developed as a complication in this case. Convalescence was very tedious, though the patient made a good recovery.

Case 4. Began February 2, the temperature rising to $100\frac{1}{2}^{\circ}$ F. the first day, with no striking symptoms but those common to influenza. The second day the temperature rose to 101° F., and the eruption made its appearance, quickly passing from the face downward over the entire body. There was conjunctivitis, and the fauces were slightly congested. Desquamation commenced on the third day. The eruption faded on the sixth day and the patient was discharged well on February 7. These four cases presented, in addition to the symptoms enumerated, most of the symptoms common to influenza which marked the other cases. There were some strong points of resemblance between them and dengue and scarlet fever, yet on the whole they were unlike either.

The treatment was generally confined to

the special symptoms as they arose. The morbid condition in itself being self-limited, and the prognosis favorable, it was thought better to care for the symptoms than to attempt to cut the disease short. In the milder cases, nothing was prescribed save rest in bed, simple nutritious diet, a room kept quiet, equally warm to suit the comfort of the patient and well ventilated. During convalescence avoidance of exposure and fatigue was enjoined.

In the severer cases and in the presence of complications the greatest skill was sometimes requisite. The tendency to abdominal congestion and gastric irritability, so frequently prominent in the beginning of the severe cases, was happily overcome by giving from 5 to 10 grains of colomel, triturated with sugar of milk, and following it with a Seidlitz powder or half an ounce of Rochelle salts, dissolved in sweetened water, one hour later. This was given on the first day, so as to secure its evacuating effect before night-fall. Then, if the suffering was severe, from 10 to 20 grains of quinine, in five-grain capsules, was administered on one dose an hour before bed-time, and was followed with from 15 to 25 grains of chloral hydrate, in five-grain capsules, also at one dose, on retiring. The quinine reduced the fever and left its happy equalizing tonic effects upon the system, while the chloral controlled the evil after-effects of the quinine on the head and ears, and produced its characteristic sleep, thus overcoming the insomnia and giving rest to the fatigued body.

The effects of this were so pleasing that the patients frequently declared themselves well on waking the following morning; and indeed they often convinced me that I was almost capable of cutting short the course of the disease.

In severe cases the same injunctions were given as to diet and avoidance of exposure and fatigue, as in the milder cases. During convalescence the best results were obtained from

R. Liquoris potassii arsenitis f $\frac{3}{4}$ ij
Syrupi hypophosphitis compositi ad . f $\frac{3}{4}$ viij

M. Sig.: Dessertspoonful three times daily.

or

R. Liquoris potassii arsenitis f $\frac{3}{4}$ ij
Elixir ferri, quininæ et strychninæ phosphatis q. s. ad f $\frac{3}{4}$ iv

M. Sig.: Teaspoonful three times daily.

The two cases of dysenteric diarrhoea yielded promptly to

R. Spiritus chloroformi f $\frac{3}{4}$
Tincturæ capsici f $\frac{3}{4}$
Tincturæ opii deodoratae f $\frac{3}{4}$ ss
Listeria f $\frac{3}{4}$ ss
Aqua menthae piperita . . . q. s. ad f $\frac{3}{4}$ iv

M. Sig.: Dessertspoonful in water every 15 to 30 minutes until stools are less frequent; then every two hours.

The case of bronchorrhœa was quickly benefited and cured by

R. Spiritus chloroformi f $\frac{3}{4}$ ss
Acidi hydrocyanici diluti f $\frac{3}{4}$
Tinctura sanguinarie q. s. ad f $\frac{3}{4}$ ss

M. Sig.: Teaspoonful in sweetened water every 2 to 4 hours.

Notwithstanding the fact that influenza has been known for centuries, its real cause is as much a mystery to-day as it ever has been. Probably at no time was the profession more eager to solve this question than at present, for bacteriologist and sanitarian have been busy ever since the last epidemic began, earnestly searching for a vital cause for influenza; and it is to be hoped that the day is not far distant when the profession will be relieved from this disease. The theories advanced have been formed upon hypothesis, without a single exception. History seems to show beyond doubt, that there are epidemic cycles; that certain periods are broadly discriminated in medical history by the wide prevalence of diseases of this sort. This was recognized as far back as the age of Sydenham, who attributed them to certain unknown changes which take place in the bowels of the earth—*pro varia scilicet ejusdem aetate ac duracione*. Somewhat more distinctly the epidemiologists of a century later attributed epidemic influenza to "cosmical" and the "telluric" agencies, which may also be expressed as those relating to the atmosphere and the soil: a division borrowed apparently from Hippocrates. Carrying these upward to higher generalizations, the learned Heser, in his *Geschichte der Volkskrankheiten* (published in 1839) predicted that the time would come when, to explain the prevalence of these great epidemic periods, men of science would find them more or less in relation to the position of the earth with reference to the plane of the ecliptic, the progression of the magnetic meridian, the alternations in the temperature and moisture

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of the earth's surface, the geological changes of water and land, and perhaps even to the progress of the solar system through space. Prof. Leyden, of Berlin, is of the opinion that influenza has sprung from dengue fever—a hybrid; and Prof. Nothnagel, of Vienna, lays great stress on its miasmic character; while others of equal repute are conjecturing on its being due to bacteria.

Does rational thought warrant our accepting such reasoning without substantial facts? We know not; for there are many reasons which operate against such a desideratum. The poison cannot be dependent upon local surroundings, or upon climatic conditions; for we find that Siberia and Italy have alike suffered, and so have Canada and Mexico, and even Central America. The rapidity with which the disease spreads indicates that the poison is such as can be transmitted by the air; while its pandemic character, the uniformity of the symptoms produced by it, and the evident constitutional involvement, all entitle influenza to rank among the specific diseases.

A few words in conclusion, and I have done. Let us ever be mindful of the fact that man is, in a measure, the servant of the conditions which surround him; but he is not their slave. He must obey them until he understands them; then he dominates them by the divine right of the rule of intelligence over material force. So it will be even with the "Pestilence that slayeth at noonday;" by studying it, he will come to know it; by knowing it, to control it.

THE GRIPPE AS A CAUSE OF ABORTION AND MISCARRIAGE.

BY W. H. BANKS, M. D.,
MIFFLINTOWN, PA.

Since the prevalence of the recent epidemic of grippe, I have been looking eagerly in the columns of medical journals for communications regarding a feature of the disease which to me seems most peculiar, namely, abortion and miscarriage in pregnant women. In one of my cases this occurred after the administration of large doses (three grains four times per day) of quinine; and at the time I attributed the miscarriage to the use of this drug; but, the more accident happening in three other cases that were not influenced by this uterine stimulant, we may very properly con-

clude that the existing influenza, and not the quinine, was responsible.

The following is a list of cases:

Case 1. Mrs. C., multipara. She had had two normal labors, and one miscarriage, which occurred after severe fright and exposure.

While in the fifth month of pregnancy she was seized with *la grippe* and, during convalescence, began to suffer from severe bearing-down pains and a slight hemorrhage. Under the use of rest and opiates, these threatening symptoms were apparently relieved, but on rising from her bed they again appeared and miscarriage followed.

Case 2. Mrs. J., multipara. She had had two natural labors. The patient was in the seventh month of pregnancy when I was summoned to see her on Jan. 4, and found her suffering severely with facial neuralgia, and also presenting the typical symptoms of *la grippe*. I prescribed quinine, twelve grains per day, and antipyrin in five-grain doses every two hours. The painful symptoms rapidly abated, but on Jan. 8, she fell into labor and was delivered of a well-formed child which, however, lived but three days.

Case 3. K. B., primipara. In the eighth month of pregnancy, while convalescing from an attack of influenza, was seized with severe bearing-down pains and a slight hemorrhage. Under the use of rest, opium and a light vaginal tampon she was finally brought to term and delivered of a healthy child.

Case 4. Mrs. B., multipara. Had had one child and one abortion. She was in the fifth week of pregnancy, when she was seized with *la grippe*. During convalescence she began to suffer from severe pain in her back, thighs and groins and had a moderate hemorrhage. This continued for two weeks, when nausea and vomiting set in, and at this time she sent for assistance. I prescribed tinct. cannabis Indica in elixir lacto-peptino and powders of bismuth and oxalate of cerium, with absolute quiet. However, twelve hours after seeing her, she aborted an ovum apparently of an eight weeks' pregnancy.

—According to the San Francisco *Examiner*, Mr. Adolph Sutro is experimenting with cinchona trees on his estate on the neighboring sea-coast. He hopes to acclimatize at least some of the varieties from which quinine is produced.

REPORTS OF CLINICS.

**VANDERBILT CLINIC.—NEW YORK.
MEDICAL CLINIC.**

PROFESSOR DELAFIELD.

Abscess of Liver.

Dr. Delafield referred to the patient who was presented at the Clinic last Thursday in whom he had made the diagnosis of abscess of the liver. The man gave the following history: Last summer he suffered from an attack of catarrhal dysentery (judging from the symptoms). In November he had an acute illness; he was confined to the house and complained of symptoms that pointed to an abscess in some location; since that time he had been steadily growing worse. Though able to be out of doors he was a sick man; he had lost forty pounds in weight. Examination showed the abdomen not distended; the liver did not extend below the free border of the ribs; yet it seemed to fill the hypochondriac region more fully than usual. Posteriorly there was marked dulness over the lower portion of the right lung. The man was admitted to Roosevelt Hospital, and the liver was aspirated, and 1000 c. c. of pus were evacuated. Only the right lobe was affected.

Dr. Delafield remarked that, from our knowledge of the manner of formation of these abscesses, that is, at the expense of the liver substance itself, there must remain but a shell of the right lobe. Hence, notwithstanding the fact that the patient has improved very much and continues to improve, Dr. Delafield is inclined to give a gloomy prognosis.

Subacute Diffuse Nephritis.

The first patient to-day was a man, 38 years old, who said he had been sick since last November. At that time, he says, he "caught cold." He had cough, with expectoration, shortness of breath, and wheezing. He lost flesh, had no appetite, and did not sleep well at night. He did not complain of headache or head symptoms, or stomach symptoms, and had no pains in any part of body. In January he was compelled to go to bed for a few days. At this time his feet swelled a little. Except for this, he has been able to work right along, though feeling that he was a sick man. His

urine is increased in quantity, has a specific gravity of 1.010, and contains a large amount of albumin. His temperature is 101°, and his pulse is 126. His body is still fairly well nourished. Physical examination of the lungs gives negative results. The apex of the heart is displaced to the left about one inch, and the heart's action is rapid, regular, and not forcible. A thrill is communicated to the hand placed upon the precordial region. A systolic murmur is heard at the apex, and also at the base—not loud. There is increased arterial tension; but the pulse is in fair proportion to the action of the heart. The skin and mucous membranes are pale. The diagnosis is therefore: hypertrophy of the left ventricle (the murmurs do not necessarily indicate valvular disease) and subacute diffuse nephritis.

The foregoing history is a straightforward one of nephritis; and there is at present still an active process going on. In the same manner it would be wrong to say of a patient with fluid in his chest and an elevation of temperature, that he had simply fluid in his pleural cavity; for in reality he would have an inflammation of the pleura and an effusion. So this man has not chronic, but an active nephritis.

The indications for treatment are, first, to put the patient to bed, where he should remain until the temperature falls, after which, if his condition improves, he could be about the house. Later, if possible, he should be sent to a warm climate. This would not be advisable as long as the nephritis is as active as it is at present.

In the beginning he should be put upon an exclusive milk diet, and Dr. Delafield said that he would test the blood, to find the proportion of hemoglobin, and also to have a positive gauge to the extent of the improvement; for the color of the skin and mucous membranes cannot always be trusted. If diminution of the hemoglobin were found, iron and inhalations of oxygen would be called for. Opium in small doses, would also be of service, particularly for its action as a cardiac sedative. Morphia sulphate, $\frac{1}{8}$ gr., four times a day, might be used for two or three weeks.

This patient has been very fortunate in having had so little dropsy. The rule in these cases is to have this a prominent symptom. It is probable that the albumin will persist in the urine for some time to come.

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specific gravity of the urine always be low, it would be natural to suppose that new connective tissue had been formed in the kidney. One examination would prove nothing.

Chronic Diffuse Nephritis.

The next patient, a man, painter by occupation and thirty-four years old, said he had always enjoyed good health, with the exception of occasional attacks of lead colic, up to one year ago. At this time he began to suffer from headaches. They would come every two or three weeks at first; but lately they have become more frequent. Since January 1, he had almost constant headaches, but less severe than before. These headaches would last from twenty-four to forty-eight hours, and would frequently be accompanied by vomiting and sometimes by convulsions. He would not lose consciousness. Between these attacks he was able to do work until December, when he entered Roosevelt Hospital. Since his last attack, which he had in the Hospital, he has had diplopia.

Examination shows a man fairly well nourished. His pulse is quick, and the arterial tension very much increased. His heart is enlarged, especially on the left side, and a loud, systolic murmur is heard at the base. The ophthalmoscope shows a neuroretinitis, with hemorrhages in the retina. The urine has a specific gravity of 1.012, and deposits about one-fourth of its bulk of albumin—the same amount as when he first entered the Hospital.

Dr. Delafield called attention to the fact that though this was a case of chronic Bright's disease; yet it presented entirely different characteristics from the preceding case. This was the form in which the structure of the kidney is altered, and in which there is no exudation from the blood-vessels. It is probable the disease has lasted longer than one year: perhaps two or three. At first the only symptoms may have been increased arterial tension and low specific gravity of the urine, with, perhaps, no albuminuria. These signs gradually advanced, and renal symptoms proper set in. Those he suffered from were attacks of acute uremia. They would be preceded by increase in the tension of the blood-vessels, then would come the vomiting, headache and convulsions, and the general health began to fail. The latest advance is found in the neuroretinitis. The pulse tension remains high,

but can be influenced by drugs. As soon as the use of medicine is stopped it relapses to its former condition.

In the treatment of this case the indications are different from those in the last case. Here there is a very chronic process, and there are no acute symptoms. That which causes the most disturbance, at present, is the disorder of the arteries. This causes the uremia. From the inflammation in the kidney directly, there are but few manifestations. It would not be necessary to send this patient to bed; nor would a warm climate offer so much for him; though it might benefit him. His diet must be partly milk and partly solid food. Iron and oxygen are not indicated. Attention should be directed towards relaxation of the arteries. Chloral in five-grain doses, four times daily, might be used at first. If this does not benefit the patient, opium should be tried, in doses sufficient to relax the arteries, one-sixth to one-fourth of a grain of sulphate of morphia may be given four times a day.

Finally, nitro-glycerin may be given three times a day, the dose being one drop of a one per cent. solution, gradually increased to the point of physiological effect, or of tolerance. The skin should be kept in the best condition by frequent bathing and rubbing.

However, in this case the treatment would be, at best, palliative. The man might improve for a time; but the nephritis and the disposition of the arteries to contract would pretty surely advance, until the time would come when drugs would have no effect in diminishing the arterial tension. Then the disease would be near the end.

In both of these cases of nephritis the prognosis is bad; in this one it is the worst.

Tumor of the Pancreas.

The next patient was a man, forty-four years old, who had been before the class last April. He had been sent from the Clinic of Nervous Diseases at that time, with the diagnosis of neurasthenia, and to see if any other disease could be made out. None was discovered, and he was sent back with the diagnosis of neurasthenia confirmed. To-day he was again sent here.

The history he gave when first before the class was that he had had syphilis thirteen years before. Two years ago he commenced to complain of pains in the right side of the back, severe at night and slight during the

day. One and a half years after this the pain was severe day and night. He was pale, had lost thirty pounds in weight, complained of frequent micturition, and had slight edema of the feet. His urine had a specific gravity of 1.026 and at no time contained albumin. Examination of the blood showed 3,879,000 red blood corpuscles to the millimeter, and 82 per cent. of hemoglobin. The heart's action was somewhat increased; but the physical signs were negative. There was no apparent cause for his sickness.

He was put upon a course of antifebrin and morphine; and his pains left him; but he still was not in good health. Six months ago—about five months after his first examination here—he commenced to notice that his stools were light colored. Three months ago he had pain in the upper part of the abdomen, which has continued. Two months ago he began to have jaundice. He had some nausea, no vomiting. He lost but little flesh. His urine now shows a specific gravity of 1.020, with no albumin, and contains bile pigment. Examination shows the man to be fairly nourished and not very markedly jaundiced.

As he lies upon the table, there is apparent a fulness in the upper part of the abdomen. It is seen to move as he breathes. By palpation, a solid mass is mapped out, which fills the right side of the epigastric region. It is hard and irregular and deep-seated. To the right of this is another tumor, small in size, with apparently fluid contents, in the region of and corresponding with a distended gall-bladder. The former tumor, which is nearly the size of the fetal head, is somewhat movable, and is connected either with the pylorus or with the head of the pancreas or the wall of the common bile-duct.

Dr. Delafield did not think it felt exactly like a tumor of the pylorus; it seemed too deep-seated, and was not as freely movable as these growths sometimes are. And again, a tumor of the pylorus of that size would produce gastric symptoms, and would have more effect on the patient's nutrition—though some patients with this condition do thrive wonderfully.

The new growth presses upon the common bile-duct, and hence the distended gall-bladder and the jaundice. All things considered, Dr. Delafield was of the opinion that it was probably a malignant growth from the head of the pancreas; and he believed that it was not present when he exam-

ined the man last April, and that it had existed about six or eight months.

PERISCOPE.

Operations for Hernia in Children.

Mr. Edmund Owen, in speaking on the subject of hernia in children, in a lecture delivered before the Medical Society of London, and reported in the *Medical Press and Circular*, Feb. 12, 1890, said that there are some herniae with which it is beyond the power of the surgeon successfully to deal with any truss whatever; the protrusion may keep up for a short while, but as soon as the child begins to get about it slips down again, and lies compressed beneath the pad. If a truss with a stronger spring be employed the pressure becomes intolerant or the skin is chafed. The medical attendant and the parents grow weary of the case, and the child is allowed to go about with a certain amount of bowel in the scrotum—an amount which generally becomes an increasing quantity. To offer an equally unsatisfactory state of affairs, though the hernia of another child is not large nor particularly unmanageable, his parents are too poor to supply him with the necessary apparatus, and too ignorant or careless to give the necessary help in making it available.

What, asks Mr. Owen, is the proper course to adopt with regard to such children? "What is their exact age?" some one may ask. This has very little influence on the question, when we have to do with ruptured children who cannot, for one reason or another, be satisfactorily dealt with in what one may call the gentle method—that is without operation. "But," rejoins the inquirer, "you surely will not advise a cutting operation for the cure of a reducible hernia in a very little child!" The surgeon's reply is that it is his duty to cure the child, and if he cannot do so in a bloodless way he must submit the child to the risk of a cutting operation. And now comes a very important point in the consideration of the question, and one of which we must not for a moment lose sight when estimating the risks of the radical treatment—unless the boy be solidly cured of his hernia he will be every day of his life in peril of a knuckle of bowel becoming strangulated. And if the strangulation occurred at a time when

and at a place where, adequate assistance is not forthcoming, or if the child—now grown into manhood, and always careless of himself—fail to call in surgical aid until the intestine has become tightly pinched for some hours; what about risk? Here, surely, is a terrible risk; yet it is the same patient, the same open funicular process, and the same hernia with which we had been dealing years before. Unfortunately, though we have diminished risk in connection with the practice of our art, we have not entirely abolished it. Indeed, every important step through life is associated with risk, and surgical progress can never be freed from it. And though we must never allow ourselves or our patients to think too lightly of surgical risk, still we shall do well in encountering it in such circumstances as we are able to select, not in those which blind chance would force upon us.

Of course, there will be some badly-ruptured children who are not suited for the radical operation—the feeble, sickly, ill-nourished and imbecile. Sir Joseph Lister has rightly said that the judicious selection of cases is an antiseptic measure, and certainly if we are to get the best results for the operative treatment of congenital hernia we must exercise considerable discretion in the choice of our subjects.

Sometimes we hear the operative treatment spoken of as the "radical cure." Radical treatment it is, and cure it may be; but to talk of it as the "radical cure" is to surround the procedure with an attractiveness which may mislead the parents of the child and disappoint the inexperienced operator. I cannot attempt to say in what percentage of cases in childhood the radical operation fails to cure the hernia, and statistics which may be prepared from the published reports can, for obvious reasons, be barely approximate. Surgical statistics which are taken over general areas, are never of much use, for the collector cannot take into due consideration such important factors of the nature of original defect, the capacity as the operator and the physical value of the patient.

The open method of the treatment of congenital inguinal hernia is based upon a very solid ground, inasmuch as it is designed simply to make good a defect which Nature had omitted efficiently to deal with. As, or shortly after birth, there should no longer be a tubular communication between the peritoneal cavity and the tunica vagi-

nalis; should the passage remain wide open a piece of bowel is more than likely to enter it, and, having once descended into it, the task of keeping it out by a truss is, as we have already admitted, sometimes one of great difficulty, and in rare instances a practical impossibility. These last are the cases for which the open method is needed.

Effect of Gastric Juice on the Tubercle Bacillus.

Zagari (as reported in the *Centralblatt für Bakt. und Parasit.*) has recently performed a number of experiments for the purpose of determining the action of gastric juice upon the bacillus of tuberculosis. After feeding dogs with excrementitious matter from tuberculous patients, and also with the organs of those dead of tuberculosis—both being proven to contain bacilli in abundance—he found that so far from suffering damage from their unwholesome diet, some of the animals even became fat upon it. The excrement of the dogs on examination proved to contain bacilli in perhaps greater numbers than that fed to them. Inoculations with these sufficed to infect guinea pigs with tuberculosis, showing that the bacilli had well resisted the action of the gastric and intestinal fluids. This is the more noteworthy, since the acidity of the gastric juice of the dog is high.

Zagari also submitted tubercle bacilli to the action of gastric juice outside the animal organism, with the following results:

After from 3 to 4 hours' exposure at 38° the bacilli still possessed their full virulence.

After from 18 to 24 hours their virulence was completely lost.

After from 6 to 8 hours' exposure, their virulence was somewhat diminished, the disease following inoculation of guinea pigs very slowly.

After from 7 to 9 hours a local tuberculosis alone could be established.

The acidity of the gastric juice of the dog equals 0.159 per cent.; that of gastric juice of consumptives whose excrement was used equals 0.0675 per cent.; that of gastric juice used in subsequent experiments equals 0.1652.

These results of Zagari agree very well with those obtained by Straus and Wurtz (see MEDICAL AND SURGICAL REPORTER, March 8, 1890), who exposed various pathogenic organisms, amongst others, that of tuberculosis, to the action of gastric juice,

having the same object in view as Zagari. Their experiments were all made outside the animal organism. Gastric juice was taken from dogs, men and sheep, and the bacilli were exposed to it at a temperature of 38° C.

Judging from these results, we must come to the conclusion that so long as the gastric juice retains a sufficient degree of acidity, tuberculosis of the alimentary canal will be unlikely to occur. The practical application is not far to seek. We must, by some means, keep the gastric juice of tuberculosis patients in its normal condition as regards acidity, or even increase it, so far as compatible with good digestion.—*Canadian Practitioner*, April 1, 1890.

Oatmeal Snares.

We have nothing to say at present concerning the numerous vaunted benefits of oatmeal as a food commodity, and, indeed, there can be no doubt that good oatmeal, properly prepared, is of benefit to the human system. But the question arises whether it is not a fact that in our present age of hurry and the desire to do things quickly, many people injure their digestive organs by eating oatmeal not sufficiently cooked, and, therefore, in a condition in which the digestive fluids cannot act upon it, leaving it undigested simply to act as any foreign body would act in the system, as a violent mechanical irritant. We are forced to this conclusion by the now too prevalent advertisements of oatmeal prepared by different manufacturers, and claimed to be so prepared as to enable it to be cooked in from three to five minutes. This is simply an impossibility. These kinds of so-called oatmeals are simply decorticated oats, which before grinding are steamed. This steaming destroys any low organisms that may be in the oats. A little bicarbonate of soda and lime is added to help dissolve the albuminoids, and in some instances diastase to increase the converting power of the starch to sugar, but there is nothing in this process that can, in our opinion, so alter the chemical nature of oats or oatmeal as to make it possible to cook it ready for easy digestion in three or five minutes. Against this snare and delusion we would warn the reader. While thoroughly cooked oatmeal, cooked in the good old-fashioned way, is no doubt a nutritious dish, these deceitful and misleading prepared oatmeals are a constant source of great danger, and, to be on the

safe side, avoid them.—*American Analyst*, April 3, 1890.

Aristol.

At the meeting of the Société de Thérapeutique of Paris, held March 12, 1890, and reported in the *Progrès Médical*, March 22, 1890, Dr. Boymond read a paper on the subject of aristol. As a remedy in skin diseases aristol is claimed to be an efficient substitute for iodoform and iodol. It is innoxious and odorless. The substance is obtained in the form of a brownish red precipitate, by treating a solution of iodine in iodide of potassium with thymol dissolved in caustic soda. Aristol is properly a biniodide of dithymol. It is insoluble in water, slightly soluble in alcohol, and easily so in ether. It may be applied in mixture with fatty oils, or as a powder to wounds and burns. It is not absorbed into the system, and no toxic action has ever been observed to follow its use. It is as efficacious as chrysarobin in the treatment of psoriasis; but it does not stain the skin nor produce conjunctivitis.

The following formula for aristol salve is recommended by Eichoff:

R Aristol 3-10 parts;
Vaseline 30 parts.—M.

It is well, after application of the ointment, to cover the affected parts with protective or rubber. The drug may be applied two or three times daily.

The Pneumatoscope.

An instrument, designed to render more audible the sounds produced by pulmonary percussion, was presented to the Berlin Medical Society at its meeting, held February 26, by Dr. Gabritschewsky, of Moscow. The instrument consists of two funnel-shaped cones, joined at the smaller ends. One of the openings fits over the patient's mouth and the other is provided with a diaphragm and is connected with the operator's ears by rubber tubes. The patient, during examination, is instructed to keep his mouth open and to breathe through the nose. The sound waves, produced by percussion, are, somehow or other, reproduced on the diaphragm.

Judging by the comments made by the members of the Society who spoke after Dr. Gabritschewsky, the instrument was not regarded by them as one of great value.

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Editorial.

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**THE
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The Editor will be glad to get medical news, but it is important that brevity and actual interest shall characterize communications intended for publication.

ANTISEPSIS IN VACCINATION.

When Jenner first inoculated for the prevention of small-pox, now over one hundred years ago, the possible occurrence of dangerous or even fatal complications was recognized, and anti-vaccinationists used this fact as their strongest argument against the practice. Cases of erysipelas and septic infection have occurred only too frequently ever since. In a large number of instances these accidents have been attributed to "bad lymph." Even in these days of advanced antiseptic surgery fatal results following vaccination are not infrequently reported, while erysipelatous complications are of so frequent occurrence as to be hardly deemed worthy of record.

Antisepsis, however crude, is but rarely practiced in vaccination. In the *REPORTER* for May 12, 1888, attention was called to this

fact, and a thorough scrubbing of the field of the operation was recommended. As a rule, the operation consists in baring of the patient's arm and immediately introducing the lymph, while, as soon as the blood dries, the sleeve is pulled down.

The possibility of septic infection being so well known, there can be no excuse for the physician failing to use strict antisepsis in vaccination, simple though the operation be. The parts should be first washed and scrubbed with a brush, using hot water and soap. This will remove all the superficial dead epidermis. The antiseptic toilet may be completed—if this seems worth while—by washing the parts with alcohol or any antiseptic solution. The lancet used should be perfectly clean. The after-treatment is of no less importance. After vaccination the abrasion should be covered with pad of boracic, or eucalyptus absorbent cotton. This will keep the limb from injury as well as prevent infection from without.

In discussing this plan of treatment in the *British Med. Journal*, Feb. 1, 1890, Mr. John Bark advises that the pad should be covered with antiseptic gauze, with the exception of its inner surface. It may be kept in place by two straps of soft half-inch tape passed around the arm, while another strap, fastened to the upper border of the pad and passing under the opposite axilla, will prevent its slipping down. Mr. Bark, however, does not apply the pad until after opening the vesicle on the eighth day, claiming that before this time, according to his own experience, septic absorption does not take place. The mother or nurse should be warned not to disturb the dressing for at least six days; when it will be found, even in cases in which there has been a large inflammatory area, that after the removal of the pad, all inflammatory infiltration will have entirely disappeared, and, in most cases, a hard, firm scab will have replaced the vesicles.

The pad has the advantage over ordinary shields, that, besides protecting the arm

from external violence, it also absorbs all the discharge and minimizes the risk of septic absorption. Ordinary shields should not be recommended since they can be used more than once and might thus easily carry infection.

It may be argued that these precautions are not called for, and will take up too much of the physician's time. But it will be found in practice that the suggestions just given can be complied with without any serious loss of time. But even if they did take some time, any method which may accomplish the abolition of such accidents in vaccination as septic infection and erysipelas is surely worthy of trial and consideration.

ADVANCE IN MEDICAL EDUCATION.

We have recently, on several occasions, referred editorially to the marked desire for an improvement in medical education, evinced by the profession in America. The movement for an extension of the medical course of study, and for a careful preliminary education is gradually becoming general. Universities, colleges and societies from all parts of the United States are joined in this laudable work. Among the colleges that have most recently extended their courses is the Starling Medical College, of Columbus, Ohio, which has determined that three courses of medical lectures shall be required of candidates for graduation, after the session of 1890-91. The Faculty of the Hospital College of Medicine, Louisville, Ky., has adopted a rule requiring all students after the sessions of 1891 to attend three courses of lectures in separate years as a condition precedent to graduation.

Our brethren in New Jersey are working towards the same end. The Camden Medical Society has appointed a committee to urge upon the New Jersey Legislature the passage of the Kalisch Bill, providing for the establishment of a State Medical Examining Board. The profession in Rhode Island has also been aroused to activity. A bill to regulate

medical practice in Rhode Island is now before the Legislature of that State. The first section of the Act provides that only registered physicians shall be allowed to practice medicine in this State, and Section 2 is as follows: "Every person in order to be a registered physician within the meaning of this Act shall be either a graduate in medicine or a practicing physician. Graduates in medicine shall be such as have obtained a diploma from a regularly incorporated school or college of medicine, and shall have presented to the State Board of Medicine satisfactory evidence of their qualifications. A practicing physician shall be deemed to be a person who for the —— years next preceding the passage of this Act has continuously practiced medicine in this State, and who shall have presented to the State Board of Medicine satisfactory evidence of his qualifications, and any other person who shall have presented to the State Board of Medicine satisfactory evidence of his qualifications to practice medicine." We sincerely trust that both the Legislature and the Governor of Rhode Island will recognize the importance of the bill and that it will speedily pass.

In Oregon a similar bill, called the Power Medical Bill, was recently passed by the Legislature of that State, but was unfortunately vetoed by the Governor, who gave as one reason, that it did not recognize sufficiently the different schools of medical practice. A new bill has now been introduced, which, it is hoped, will prove acceptable to the Governor.

The necessity for a graded course of study in any branch of science is apparent, but it is especially urgent in the study of medicine, with all its bewildering complexities, and as yet but half discerned truths. It is, therefore, appalling to estimate the number of comparatively illiterate men who, during recent years, after a few months of desultory study, and in the face of the present advanced state of the science of medicine, have attained, in colleges in this country,

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It is the duty of every medical organization to stimulate and endorse every effort of State or Society, directed towards the correction of the existing faults in medical education, and the furtherance of advanced methods; and now that the profession has been fully aroused to the desirability both of an extended course of study and of a preliminary training, the establishment of both should be striven for in every city and State.

We trust that ere long this will be the case, and also that every State shall have a competent medical examining board, and that the medical profession in the United States will be elevated to its legitimate position. It will always be the policy of the *REPORTER* to give this most important subject prominence, and to report to its readers every advance made in this direction.

PUNCTURE OF THE INTESTINE FOR OCCLUSION.

At the last meeting of the French College of Surgeons, Professor Demons, of Bordeaux, advocated the practice of making punctures into the intestine in the treatment of chronic occlusion of the bowel, and deprecated the unmerited disuse—as he thinks it—into which this method has fallen. Among the advantages which he claims for it, is the fact that after relieving the bowel of the gas which has inflated it, it is often possible—on account of the flaccid condition of the belly-wall—to determine the cause of the occlusion and to institute intelligently some other procedure to overcome or remove it. Professor Demons speaks of the operation of puncture as being only a palliative measure, and yet he reports six cases in which it was followed by permanent relief of the condition of obstruction. One of the most striking features of his communication was the statement that he has never seen any ill-effect to follow the making of punctures in

the bowel; while in the most unsatisfactory cases it gave at least temporary relief to the patient.

These opinions of Professor Demons were published in the French medical journals as long ago as last October; but they do not seem to have attracted the attention which they deserve. He speaks of a sort of revival of the method in England; but this is somewhat of a euphemism; for in England, as in this country, most surgeons regard such a procedure as in the highest degree dangerous. There and here, we believe, there is hardly a surgeon who would consider it justifiable to puncture the intestines except in extreme cases, and in the face of impending death from suffocation caused by pressure of inflated intestines upon the diaphragm.

Nevertheless, it may be that there is something to be said in favor of aspirating the intestines, and that this is not so dangerous as most surgeons think. There are times when the relief furnished by such a procedure may be of the greatest advantage. Not long ago, in Philadelphia, a woman, dying in consequence of a fracture in the cervical portion of the spinal column, who was being suffocated in consequence of the accumulation of gas in the intestines, was relieved by means of puncturing the intestine with a fine aspirating needle sufficiently and for a long enough time to make a will. In another case a patient dying of peritonitis was relieved so much as to encourage the belief that the operation had proved of great service in lessening the discomforts of his inevitable death.

In cases of this sort we believe that puncturing the intestines is a measure which ought to be resorted to, and can believe that in some cases it may prove of more than temporary utility. Certainly the very strong and positive statements of Professor Demons suggest that there may be too much dread in the minds of surgeons in regard to this procedure, and that it may have a field of usefulness which warrants a more general consideration than it has heretofore enjoyed.

ESSENCE OF CINNAMON AND TYPHOID FEVER.

The newspapers of April 19, 1890, report, under the heading, "Highly Important, if True," that a discovery of vital importance has just been made by Dr. Chamberland, Pasteur's assistant, and Drs. Mennier and Cadéac, which proves that essence of cinnamon, when sprinkled in the rooms of a typhoid fever patient, kills the bacteria within twelve hours and prevents the disease from spreading.

This curious item may have originated at Pasteur's laboratory; for many strange things have come from that source; but it would probably be unjust to charge it with one which displays so many different marks of ignorance as this one in regard to typhoid fever does.

BOOK REVIEWS.

[Any book reviewed in these columns may be obtained upon receipt of price, from the office of the REPORTER.]

ANÆSTHETICS, ANCIENT AND MODERN: Their physiological action, therapeutic use and mode of administration; together with an historical resume of the introduction of modern anaesthetics—nitrous oxide, ether, chloroform and cocaine; and also an account of the more celebrated anaesthetics in use from the earliest time to the discovery of nitrous oxide. By GEORGE FOY, F. R. C. S., Fellow of the Royal Academy of Medicine in Ireland, etc. 8vo, pp. 175. London: Ballière, Tindall & Cox, 1889.

The greater part of this volume has appeared in the shape of monthly contributions to the *Dublin Journal of Medical Science*, during the years 1888 and 1889. The author states in his preface that his object in undertaking the work was not to rob the men of the present day of discoveries rightfully theirs, but to give credit, where credit is due, to the ancients. He has endeavored to bring from the relics of the almost forgotten past whatever may tell of the gradual evolution of the anaesthetics of to-day from the first crude attempts of ancient medical men to find a suitable analgesic. Mr. Foy divides the history of anaesthetics into three periods: First, the period of crude drugs, which lasted until the discovery of distillation, and was associated with superstition often of a gross character; second, the period of distilled products, which lasted until the isolation of oxygen; from which event may be dated, third, that of the inception of the discovery of modern anaesthetics.

The history of the use of various agents to relieve pain, as related by Mr. Foy, is extremely interesting. It is evident that the ancients were familiar with mandragora, opium, and cannabis Indica, and perhaps they actually used, in some instances, anaesthetic gases. The story of chloroform and ether is more familiar to most persons. Americans will be glad to know that

full credit is given them for the discoveries of Guthrie and Jackson. Regarding the safety of chloroform, even in patients with heart disease, the author quotes Dr. Lawrie's opinions concerning the experiments performed by the Hyderabad commission, and also quotes freely from our countrymen, Drs. Hunter McGuire and Chisolm. Throughout the book he shows an appreciative familiarity with the contributions of American writers. Some useful general rules for the administration of anaesthetics are given in Chapter XIV.

Dr. Foy has made an interesting collection of historical references to anaesthetics, and has grouped together some valuable observations on the more important of them now in use. The book is written in a pleasing style, and a manifest spirit of fairness pervades it. Altogether the book is instructive, and it fulfills a useful purpose.

A HANDBOOK OF DISEASES OF WOMEN, INCLUDING DISEASES OF THE BLADDER AND URETHRA. By DR. F. WINCKEL, Professor of Gynaecology, and Director of the Royal University Clinic for Women in Munich. Authorized Translation. Edited by Theophilus Parvin, M. D., Professor of Obstetrics and Diseases of Women and Children, in Jefferson Medical College, Philadelphia. Second Edition, Revised and Enlarged, with 150 Illustrations. 8vo, pp. 756. Philadelphia: P. Blaististon, Son & Co., 1889. Price, \$3.00.

The character of Winckel's Hand-book of Diseases of Women is so well known as not to need extensive notice. The author is a recognized authority, and a man of great learning, wide experience and conservative judgment. The book is what we should expect from such an author.

The present edition contains a section upon the diseases of the bladder and urethra in women, derived chiefly from Winckel's monograph upon that subject.

As placing before English readers the views of Winckel, the Editor and Publishers are to be congratulated for issuing the work. But the student and practitioner must bear in mind that the opinions expressed are not recent, and that in the sections devoted to subjects in which rapid advances have been made, the accepted teachings of to-day are not set forth. This refers more especially to the sections devoted to pelvic inflammation and abdominal surgery.

It gives us great pleasure to add that this fact is frankly stated in the Editor's preface. The thoroughly scientific character of the work gives it such value that it will be an addition to any library.

CORRESPONDENCE.

Pseudo-encephalic Monster.

TO THE EDITOR.

Sir: In the REPORTER of Jan. 18, 1890, appears an article entitled "Pseudo-cephaloid Infant," the description tallying so closely to my experience that I have decided to put it in print for the benefit of my brothers who are just commencing to practice.

In August, 1887, I was called to my first case of confinement. The patient was Mrs. B., 35 years old. She had before given birth to five well-formed children, all of

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whom we generally seat beside them, and little trouble I felt quite an examination mother contents and spasms never had her previous examination text present mass of sun I kept my mother that every time. It standing up a creep up a of a hundred taught by none of the backward tell her so that the last instruments wise look, tion; but were now seemed to waited this seemed still allowing me Again I came mass, and went up a considerable edges of the puzzle amination root of the my finger, presenting what to the mystery to After se child, well was born. spiration w the pulsati several pecies and lived on The front portion

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Correspondence.

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whom were living at the time, the family generally in the best of health. I took my seat beside the mother, asking many questions, and learned from her that she had but little trouble in her previous confinements. I felt quite encouraged, as I had not made an examination. After a few minutes the mother complained very much of the movements of the child, they being very strong and spasmodic—more so than usual, as she never had experienced such movements in her previous confinements. I made an examination and found, as I thought, the vertex presenting; but at the same time I felt a mass of substance that I could not make out. I kept my own counsel, only assuring the mother that the head was presenting, and that everything would be over in a short time. It seemed to me that my hair was standing on end, and the chills began to creep up and down my spine, and I thought of a hundred different things that had been taught by the professors of obstetrics. But none of them seemed to fit this case. I felt backward in making the second examination for fear of the mother's reproach, should I tell her some other part was presenting, and that the labor might be tedious, or that instruments might be required. I put on a wise look, and made the second examination; but found no progress. The pains were now few and weak, but the mother seemed to be in the best of spirits. I waited thirty minutes. Labor at the time seemed stimulated, and I made my third examination. The head had come down, allowing me to make a good examination. Again I came in contact with the peculiar mass, and the chills resumed their movement up and down my back. After considerable manipulation I could feel sharp edges of bone surrounding the mass; and the puzzle seemed to deepen. Further examination brought the depression of the root of the nose and eye within reach of my finger, and then I was sure the head was presenting; and I felt greatly relieved. But what to think of the soft mass was still a mystery to me.

After several hard labor pains a male child, well formed except as to the head, was born. It weighed eight pounds. Respiration was established immediately; and the pulsation was good. The child made several peculiar sounds, but could not nurse, and lived only eighteen hours.

The frontal, the parietal, and the squamous portion of the temporal bones were ab-

sent. The eyes remained open. The soft mass was of a dark red color, resembling liver. It was covered with a dense membrane, dipping down and dividing the mass into five distinct sacs, which were filled with fluid. No brain substance could be distinguished. The child was carried to full term. I was not allowed to make a minute examination, and a fuller description of the mass cannot be given. To say I felt relieved at the easy termination of the labor is putting the matter very mildly.

Yours truly,

B. F. HARDING, M. D.
Crestline, Ohio.

Strange Remedies.

TO THE EDITOR.

Sir: A Mr. Haw, writing from South Africa to the London *Lancet*, describes some of the remedies relied on by the people of Transvaal. They are not new to me or original with that people. Twenty years ago I began practice near the foot of Lake Champlain, and most of the remedies mentioned were in vogue there. They are survivals of medicine handed down from their common Dutch ancestors. Many of these old absurdities may still be found in America among the descendants of any European nationality.

Cow-dung poultice, which he mentions, is in very common use. Turning to Salmon's *London Pharmacopœia* of 1620, I find it there quoted as a standard remedy, not only for external but also for internal use. He gives a formula for *Tinctura Sterci Bovis*. "It is of a cleansing faculty, temperate in quality and a great Anodyne. Good against all diseases." Several preparations follow: one of which is *Hedychrum*, "Perfume of cow-dung, gathered in May, June or July and distilled. Cooling, di-
cussive, carminative."

He speaks of a young goat killed and immediately opened, into which a child is put. He does not mention for what disease, presumably for pneumonia, as I have seen it done, except that it was into a sheep instead of a goat. For peritonitis a common remedy is to cut open a live black hen and apply it to the abdomen. For sprain, the warm entrails of a sheep or hog.

Eel-skin strings or strips he mentions as used for rheumatism. I have seen many men wearing these strips about their wrists and ankles for stiffness there. It is a com-

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mon practice in the by-ways of New England to tie a hank of flax or a skein of linen thread around the waist of a child having mumps "to prevent them from going down." I do not find this in Salmon.

Mr. Haw saw them use the finely chopped hairs of a black cat that had no trace of white on it, mixed with sugar, for convulsions. I have known this to have been given for worms, and also found a patient's breast that threatened to suppurate covered with an ointment made with the hairs and lard.

The blood from the black cat is often applied as a remedy for shingles.

This is in the old *Pharmacopœia*:

"Fowl-poultice for snake bite." It was commonly used for dog or cat bite. In Salmon's *Dispensatory* it is written, "the Anus of a live Fowl applied to a Bubo draws out the Poyson, by its attractive quality." For jaundice, scoop out a carrot, fill it with the urine of the patient and hang it against the back of the chimney. When the urine evaporates, the person recovers. I was called to see a patient for which the remedy had failed. The old lady said it was useless, unless done in the dark of the moon.

Children still practice counting warts to make them disappear; but I had supposed hanging them in effigy was original with my community. I have seen the chimney-back many a time decorated with a rude drawing of a gallows with ropes dangling and knotted ends to represent the warts. When the smoke effaced this the warts disappeared.

For wounds made by a nail or splinter, to wrap the implement in a soft cloth and to lay it in a warm place, is a common practice. Last summer I saw the village farrier carefully wash a horse's wound, made by a barbed-wire fence, then lay in it two small sticks cut from a sweet apple tree; these he then wrapped in a paper and placed them carefully over the kitchen stove. No other treatment was given to the ugly wound. He said he had practiced this for forty years, sometimes on men, and had never failed of a successful cure. It was a queer reminder of the sympathetic powder of Sir Kenelm Digby, with which the sword was anointed and carefully dressed for the cure of the wound. King James I gave him a large reward for it (1658).

There are many new things under the sun nowadays, but there are many of the old things surviving. Yours truly,

P. J. F.

Clinton, Iowa.

NOTES AND COMMENTS.

The Commitment of the Insane to Asylums and Hospitals.

At a meeting of the New York Neurological Society, held February 4, 1890, a committee, appointed at the preceding meeting to examine the proposed new lunacy law, known as the Gallup Bill, reported that the measure has a large number of very excellent features, which, if they should become law, would prove of the highest advantage to the unfortunate whom they are intended to benefit. These are the sections relating to:

1. The removal of the insane to asylums by attendants of the same sex.
2. The admission and discharge of voluntary patients.
3. The admission of emergency cases without papers of any kind for three days.
4. The forbidding of the confinement of insane persons in jails in the same room with criminals, and any detention beyond ten days.
5. The provision of home visits of indefinite duration at the discretion of the medical officers of the asylums.

6. The boarding-out of suitable chronic lunatics in private families, at county expense, according to the systems in vogue in Scotland and Massachusetts.

Aside from the invaluable particulars just described, there are several sections relating to commitment to which there would seem to be serious objections.

According to the present law, the family physician calls in another physician. Together they make out two medical certificates and swear to them before a notary. (This is all sufficient for admission to the asylum for five days.) A judge of a court of record must write his name and the word "approved" on the back of the certificates to make them valid beyond the five days. The papers must not be over ten days old when the patient is admitted.

According to the proposed law, the family physician makes out a formal paper notifying a judge, justice of the peace or superintendent of the poor that a patient of his is insane and a proper subject for an asylum. The official thus notified fills out two blank forms directing two physicians to examine the patient. The physicians make out two medical certificates, which are returned to said official. If the officer notified be a justice of the peace or superintendent of the

poor, he receives and satisfies the certificate, then sends proceedings, him to the court for the patient, move him cause copies filed in the estate of the case as to The process paper has perintendent patient, no also to be office of the At present for the com- tial for the proposed t and simplifying the laws, acc bill must be passed is accom The objec- zte: 1. It is u 2. The p will be dep labors. 3. Pati tion of the county offic the court w proceedings. The compari- as is no person h wrong-doing in New Yo make certain in force, no commitment, bu submitted the 1. There the present medical cer-

poor, he must himself also visit the patient and satisfy himself as to his insanity, after receiving the certificates of the physicians. He then makes out himself a corroborating certificate, and presents the three certificates to a judge of a court of record. The judge then sends notice to the patient of the proceedings, makes out an order committing him to the asylum, and finally issues a warrant to the asylum superintendent to send for the patient, or to a county official to remove him thither. The judge must also cause copies of the medical papers to be filed in the office of the county clerk; and he must furthermore take proof as to the estate of the patient, filing another certificate as to these facts with the county clerk. The process is only completed after a formal paper has been made out by the asylum superintendent to the judge committing the patient, notifying him of the admission of the case. The judge must cause this paper also to be filed with the other papers in the office of the county clerk.

At present two papers only are necessary for the commitment of a patient to a hospital for the insane. According to the law proposed thirteen papers will be required; and simplified as much as possible by avoiding the lower officers and applying directly to the judge of a court of record, twelve papers, according to forms prescribed in the bill must be made out before the legal process is accomplished.

The objections to this form of procedure are:

1. It is unnecessarily complicated.
2. The position of Examiner in Lunacy will be degraded to a reward for political labors.
3. Patients will suffer harm from the visitation of two strange physicians, of the county official or judge, and of an officer of the court with a notification of the legal proceedings about to be instituted.

The committee says that, simple in comparison as is the existing law of commitment, no person has ever been, through intentional wrong-doing, placed in an asylum as insane in New York State. But it is possible to make certain improvements in the law now in force, not only in the manner of commitment, but also in the means of regaining subsequent liberty; and the committee submitted the following suggestions:

1. There should be no material change in the present mode of commitment by two medical certificates, sworn to, and approved

by a judge of a court of record, as provided in the Laws of 1874.

2. Emergency cases should be received for three days without papers of any kind, as specified in the proposed new law.

3. The medical certificates should be more carefully and thoroughly made out, not only in justice to the patient, but also for the benefit of the asylum physicians, who now rarely receive many facts bearing upon the medical history of their patients or upon their mental condition. To this end the form prescribed in the Gallup Bill should be adopted. A few additional questions should be incorporated in the medical certificate for the purpose of determining whether the physicians have informed the patient of their intention of placing him in a hospital for the insane for treatment, in order to guard against the serious harm so often done to patients by removing them to an institution through deception. The State Commission in Lunacy seems to be invested with the power to prescribe the form in which the medical certificate should be made out, and a law regulating this would not appear to be necessary.

4. There should be a section in the law permitting any higher-justice, upon application from any patient in an asylum, to appoint at his discretion a commission of two or three physicians to quietly examine said patient as to his mental condition, and upon receiving their report favorable thereto, to discharge him from the custody of the asylum.

5. A clause should be introduced into the bill providing that nothing in the lunacy laws of the State shall be construed to interfere with the reception and treatment of acute cases of insanity in chartered general hospitals, in the same manner and under the same conditions as patients suffering from other diseases are there received and treated, provided such hospitals have suitable accommodations approved by the State Commission in Lunacy.

Diphtheria—its Treatment.

In the *North Carolina Med. Journal* for March, 1890, Dr. E. B. Goelet, of Saluda, N. C., has an excellent practical paper on diphtheria, in which he says:

The symptoms vary from simple sore throat to complete constitutional prostration. Usually there is, at first, a malaise or tired feel-

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ing, with loss of appetite; next the throat becomes sore, and there is languidness with fever; then the eyes get dull, showing constitutional depression and feebleness; the tonsils are only slightly enlarged out of proportion to the constitutional symptoms; then appears a general redness of the palate, pharynx and tonsils, with dusky reddened blotches and white or ash-colored spots, spreading rapidly and developing in glandular enlargements; the inflamed surface exudes false membranes containing micrococci, which inoculates all other surfaces in contact therewith; and finally the disease expresses itself anywhere on the body there is an abrasion. If let alone the tendency is to death by suffocation, on account of the spread and rapid growth of these false membranes. The involved cervical glands increase enormously. Blood-clots may form and attach themselves to the valves of the heart, then be swept off as emboli.

In tonsillitis there is a sharp attack of fever, high temperature and enlarged tonsils, with no history of malaise, the eyes are bright, there is no languor or prostration, the swelling and redness confined to the tonsils.

In follicular tonsillitis there is no fever, no constitutional depression, but very enlarged tonsils on both sides, covered with patches in the depressions of the tonsils, but these patches are superficial and easily removed; in a day or two, under proper treatment, the patches reduce in size and soon disappear.

In scarlet fever the symptoms resemble diphtheria, but the eruption appears in the first twenty-four hours, the throat symptoms come on later, and the redness is scarlet and difused.

In diphtheria the fever is slight, of low grade, resembling an asthenic type, the eyes are dull, and there is constitutional depression, simple enlargement of the tonsils, inflamed palate and pharynx, with whitish spots or patches appearing upon a reddened base, the spots are adherent and apt to cause a flow of blood when removed, there may be an eruption, but that comes on later; the early symptoms are confined to the throat, the patches spread rapidly and inoculate all surfaces in contact with them.

The treatment should be based upon constitutional theory. A proper germ poison put into the blood will arrest its development and destroy the membrane. Sulphur and chlorine are the most potent germicides known. Now we want to get sulphurous acid into the

blood; and, in order to do so, we give the sulphite of sodium. It will not hurt the patient, but will destroy the germ and be excreted by the kidneys as a sulphate. From twenty to thirty grains taken every two hours will keep up a continuous action; large doses act as a purgative, but do no harm. As a local application, use chlorine water. I usually generate it in this way: Take chloride of potash, 3 ij; and hydrochloric acid, [The writer probably meant to say sulphuric acid. Ed. REPORTER.] m. xx; put into a well-stoppered eight-ounce vial, and when decomposition has taken place, add through a glass funnel, glycerine f. 3 ii, to absorb the chlorine; then add water to fill the vial. Use this as a gargle, and it will clean off the membrane as a wet sponge does a slate. It can be even given in doses of f. 3 i every three hours. As a prophylactic, I prefer the sulphite of sodium; for chlorine is a powerful cardiac stimulant and diuretic, and is best suited to severe cases. I have had a number of cases this fall and winter and have lost only one.

I have a firm conviction that, if called to see the patient in time, with this treatment there should be no fear as to the result.

Absence of Malaria on the Eastern Shore of Maryland.

In a pamphlet on the Climate of the Eastern Shore of Maryland, Dr. C. W. Chancellor, Secretary of the Maryland State Board of Health, says that for a long time the Eastern Shore of Maryland has rested under a reputation such as is likely to arise from a careless observation of her physical constitution and relations; but the light of investigation and experience has in a measure dispelled this belief.

The salubrity of any particular locality cannot always be exactly interpreted from local conditions, or a mere string of figures be said to represent meteorological phenomena. They are, however, very valuable in conjunction with other knowledge; and any information obtained from intelligent physicians and other persons who have lived long in a place, as to its general salubrity is valuable in forming a judgment of the healthfulness or unhealthfulness of a locality. He has gathered as much of such knowledge as possible in regard to the salubrity of the Eastern Shore. Reports from a considerable number of local health officers, physicians

and correspondents have been sent in from the State, and cases, in fully healthy condition, of equal severity especially among children and pulmonary diseases. The facts indicate that the disease diminished or disappeared in areas affected by portion of all other causes, two per cent. number of better known cases of disease, and application of intermittent antimalaria from the Eastern States.

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and correspondents show that, whatever may have been the condition of this section of the State, as regards malarial and other diseases, in former years, it is now exceptionally healthy—in fact it is more exempt from disease than any other district in the State of equal area and population. This is especially true in respect to malarial fevers and pulmonary consumption.

The facts which have been obtained indicate that malarial diseases have greatly diminished on the Peninsula in the past ten or fifteen years, and that, exclusive of small areas affected by local conditions, the proportion of uncomplicated malarial fevers to all other cases of disease is not more than *two per cent.* This great reduction in the number of cases has been secured through a better knowledge of how to avoid the causes of disease, rather from any system of medication; and it is hoped that, by further application of well-known sanitary laws, intermittent and remittent fevers will be banished from the list of prevailing diseases on the Eastern Shore of Maryland.

The Dispensing of Digitalin.

The Paris correspondent of the *Chemist and Druggist* reports on a discussion on digitalin recently held at a meeting of the Paris Société de Pharmacie, as follows:

M. Petit called attention to the vexed question of digitalin, or rather digitalins. As regards crystallized digitalin there is no difficulty when it is prescribed as such. The dose is one-tenth of a milligramme, and it makes but little difference whether Nativelle's or the German crystalline principle (by them called "digitoxin") or any other be employed. But the trouble is with amorphous-digitalins. According to law it is this sort that should be dispensed when no remark is made by the prescriber, and the preparations offered in the market as amorphous digitalins are exceedingly variable in strength. Some, such as the Codex article, which are completely soluble in chloroform, are considered by good authorities nearly equal to the crystallized principle; but others must be much weaker, since they are taken in 1-mg. doses, which would be sure death with the pure product. As to the German sorts offered, they are of all varieties and prices, from less than 1 franc or 3 francs a gramme, not to speak of the so-called digitoxin. In consequence of this

great variation, M. Petit moved that a commission be appointed on the question, so as to arrive at some agreement in regard to uniform practice in dispensing digitalin. The motion was unanimously concurred in, and MM. Petit, Marty, Wurtz and Delpech appointed a committee to consider the matter and report.—*American Druggist*, April, 1890.

Curability of Hydrophobia.

In the data collected by Dr. Lucas Benham, and published in the *Lancet*, March 1, 8 and 15, 1890, there is a fair amount of the evidence that hydrophobia may be successfully treated. This evidence does not, however, afford much satisfaction, inasmuch as the cases on which most reliance has been placed—those, namely, where bleeding and salivation have been freely employed—are derived from the records of the early part of this century. In many of the narratives supplied by Dr. Benham there is a candid confession respecting the doubtfully rabid condition of the animal that inflicted the bite. In others the symptoms seem to be exaggerated. Dr. Benham's candor and impartiality are to be commended.

Pitjecor.

Pitjecor is the name given by Dr. Luigi Casati to a preparation of cod-liver oil and catramin. It is free from fat, but not emulsified. It is said to be of special value in chronic affections of the lungs, particularly in tuberculosis. Catramin (a preparation made from pix liquida) is said to act directly upon the tubercle bacillus. The results obtained by Dr. Casati with the preparation were most encouraging.—*Wiener med. Presse*, Feb. 23, 1890.

Hydrophobia in Paris. Pasteur Institute Statistics.

The *Bulletin Médical*, March 26, 1890, reports that in the year 1889 there were treated at the Pasteur Institute 236 persons from the Department of the Seine (Paris) alone, supposed to have been bitten by rabid dogs. Of these persons three died after treatment. During the same period three other persons died of hydrophobia in Paris.

NEWS.

—Dr. Robert Coltman, of Chinanfu, China, on April 1, 1890, assumed charge of the Teng Chow Fu Hospital.

—The Board of Charities and Correction, of Philadelphia, on April 16, elected Dr. J. M. Barton, surgeon to the Philadelphia Hospital in place of Dr. Henry R. Wharton, resigned; and Dr. C. Jay Seltzer was elected laryngologist.

—The Medical Society of the Missouri Valley held its regular quarterly meeting in St. Joseph, March 20 and 21. The Society was organized over a year ago at Council Bluffs, Ia., and now has a membership of over two hundred.

—A professor in the University of Klauzenburg claims to have compounded a solution which completely neutralizes the poison introduced into the system by the bite of a mad dog. This solution consists of chlorine water, salt brine, sulphurous acid, permanganate of potassium and eucalyptus oil.

—The sixty-ninth annual commencement of the Philadelphia College of Pharmacy took place April 17. The valedictory address was delivered by Professor Joseph P. Remington, Ph. M. Among the graduates were five women, two of whom did not receive their diplomas, being under twenty-one years of age.

—It is reported that two families, consisting of sixteen persons, were poisoned last week in Franklin County, Arkansas, by eating wild turkey, and twelve of them, up to the last accounts, were not expected to survive. It is believed that shortly before being shot the turkey ate some strychnine bait which had been set for wolves.

—A dairyman of Chester County, Pa., has complained to the health authorities of Philadelphia about the filthy condition in which milk cans were sent back to the dairies. He stated that very frequently these cans are allowed to stand for weeks with milk decaying in them and breeding impurities which decomposed animal matter is subject to.

—Professor Ulysse Trélat, the distinguished French surgeon, died March 28. For many years past Dr. Trélat had been Professor of Clinical Surgery in the Academy of Medicine, of Paris. He was sixty-two years of age. He took his degree in 1854. Military honors were rendered the deceased at his funeral and several orations were pronounced over his grave.

—The New York Pasteur Institute was

opened on February 18, and from that date to March 31 thirty people applied for relief. Of these 9 were treated, and are at present in good health. In 3 cases hydrophobia was assumed to exist from the results of inoculation of other animals with the spinal cord of the rabid dogs. Four of the patients were from New York City, 3 from Long Island, and 1 each from Maryland and Arkansas.

—The following medical commencements have been held recently:—Fort Wayne Medical College, March 11, 7 graduates; Beaumont Medical College, March 20, 23 graduates; Central College of Physicians and Surgeons, Indiana, 8 graduates; Medical College of Indiana, 28 graduates; Western Reserve University, Cleveland, O., March 5, 30 graduates; Atlantic Medical College, 51 graduates; Southern Medical College, March 5, 33 graduates.

—The National Academy of Sciences, in Washington, on April 18 elected as members of the Academy, George L. Goodale, Professor of Botany in Harvard College; Russell H. Chittenden, Professor of Chemistry in Yale College; Richard M. Smith, Professor of Political Economy in Columbia College, New York, and General Thomas L. Casey, Chief of Engineers, U. S. A. One vacancy remains unfilled, it having been found impossible to agree upon the persons most worthy to be honored.

—The druggists of Baltimore have been much exercised over the provisions of the new Liquor License law. A largely attended meeting was held April 17, to discuss the new law. The law was characterized as absurd, and it was stated that if it were enforced literally, the druggist would be legislated out of business. A committee was appointed to consult with the State's Attorney, and get a written statement of the construction the druggists are to put upon the law, and the extent to which their business as now conducted will be affected by it.

—Twenty-two physicians who were employed on the summer vaccinating corps by the Brooklyn Health Commissioner, and who have not been paid for their services, have employed lawyers and had claims filed preparatory to suing the city. They have not been paid because the Civil Service Commission said they were irregularly employed. Commissioner Griffin employed them in an emergency, believing that he had full power to do so. There is no question as to the performance of the work charged for. The amount of the claim in each case is \$120.

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